NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* first as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council. The Secretary of State publishes the notice along with the Preamble and the full text in the next available issue of the *Arizona Administrative Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED

PREAMBLE

1. Sections Affected — Rulemaking Action

R9-27-101	Amend
R9-27-201	Amend
R9-27-202	Amend
R9-27-203	Amend
R9-27-204	Amend
R9-27-205	Amend
R9-27-206	Amend
R9-27-207	Amend
R9-27-208	Amend
R9-27-209	Amend
R9-27-210	Amend
R9-27-211	Repeal
R9-27-301	Amend
R9-27-302	Amend
R9-27-303	Amend
R9-27-304	Amend
R9-27-305	Amend
R9-27-306	Amend
R9-27-307	Amend
R9-27-308	Amend
R9-27-309	Amend
R9-27-310	Amend
R9-27-401	Amend
R9-27-402	Amend
R9-27-403	Amend
R9-27-404	Amend
R9-27-405	Amend
R9-27-406	Amend
R9-27-407	Amend
R9-27-408	Repeal
R9-27-501	Amend
R9-27-502	Amend
R9-27-503	Amend
R9-27-504	Amend
R9-27-505	Amend
R9-27-506	Amend
R9-27-507	Amend
R9-27-508	Repeal
R9-27-509	Amend
R9-27-510	Amend
R9-27-511	Amend
R9-27-512	Amend
R9-27-513	Amend
R9-27-514	Amend
R9-27-515	Amend

R9-27-516	Amend
R9-27-601	Repeal
R9-27-601	New Section
R9-27-602	Repeal
R9-27-603	Repeal
R9-27-701	Amend
R9-27-702	Amend
R9-27-703	Amend
R9-27-704	Amend
R9-27-705	Amend
R9-27-801	Amend

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

   Authorizing statute: A.R.S. § 36-2912(G)(6)

   Implementing statute: A.R.S. § 36-2912

3. **The effective date of the rules:**

   July 15, 1997

4. **A list of all previous notices appearing in the Register addressing the final rule:**

   Notice of Rulemaking Docket Opening
   2 A.A.R. 3557, August 9, 1996

   Notice of Proposed Rulemaking
   2 A.A.R. 742, March 7, 1997

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

   Name: Cheri Tomlinson

   Address: AHCCCS Administration
   Office of Policy Analysis and Coordination
   801 East Jefferson, Mail Drop #4200
   Phoenix, Arizona 85034

   Telephone: (602) 417-4198

   Fax: (602) 256-6756

6. **An explanation of the rule, including the agency's reasons for initiating the rule:**

   The rule changes are necessary to:

   Comply with the provision set forth in A.R.S. § 362912(G)(6), which requires the Healthcare Group of Arizona rules to stand alone and not be dependent upon references to the AHCCCS Administration rules;

   Add definitions as they apply to subject matter discussed elsewhere within the rules;

   Change the program name from Health Care Group to Healthcare Group of Arizona, the program name which is registered with the Secretary of State;

   Clarify the pre-existing condition limitations and portability requirements as specified in A.R.S. § 36-2912(I) (credits to members who had continuous coverage);

   Grammatical changes; and

   Clarify and make the grievance and appeal rule language consistent with actual practice.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**

   Not applicable.

8. **The summary of the economic, small business, and consumer impact:**

   Laws 1995, Chapter 260, § 6 (SB 1309) contained a number of provisions related to the Healthcare Group of Arizona that modified state statute and resulted in the changes to the 8 Articles in Chapter 27. While most of the changes are made for clarification or grammatical purposes, other significant changes are necessary to comply with provisions in A.R.S. § 36-2912 that:

   Require rules for Healthcare Group of Arizona to stand alone and not be dependent upon references to AHCCCS rules;

   Clarify pre-existing condition limitations and portability requirements. Healthcare Group (HCG) Plans are required to provide coverage to individuals with pre-existing conditions, if the individual meets portability requirements of the law. The changes require HCG plans to provide eligible employees with a credit of 1 month for each month of continuous coverage, of 60 days or more, that the employee had through another HCG Plan or accountable health plan; and

Permit HCG Plan contracts to be awarded to commercial insurers without requiring that the Plan have a contract to provide AHCCCS acute care services.

The changes are designed to comply with state statute and make the rules more user friendly by clarifying the roles and responsibilities of all parties involved in paying for and providing services to HCG members. There will be a slight to moderate economic impact on HCG Plans, none of which are small businesses, in complying with the pre-existing condition limitations and portability requirements in A.R.S. § 36-2912(I). HCG members may be subject to higher or lower copayment amounts depending upon the level at which copayments are set by the HCGA. HCG members, Health care providers providing HCG services, and HCGA will be directly affected by, and benefit from, the changes.

The larger business community will not be impacted by the changes. In addition, 21 political subdivisions that are HCG Employer Groups, will remain unaffected as will American Indian Tribes and Nations.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**
The changes between the proposed rules and the final rules are minimal. This is primarily due to the fact that AHCCCS provided stakeholders with a "courtesy copy" of the rule packet prior to the public hearing held on April 9, 1997. Comments were received from the health plan and 3 transportation providers. These comments were incorporated into the final rules.

The differences between the proposed rule and final rule include:

Grammatical, verb tense, and punctuation changes throughout;

Clarified the definition "political subdivision" in R9-27-101(34);

Revised the language in R9-27-209(A) and R9-27-209(B) to specify that the member or provider is responsible for notifying the Plan within 24 hours after the initiation of treatment;

Revised the language in R9-27-205(12) to clarify that treatment is covered for no more than 60 days;

Revised the language in R9-27-209(C) to identify the provider as being responsible for notifying the Plan of a transport within 10 working days rather than 24 hours; and

Revised the language in R9-27-703(C) to add "including emergency services" after "payment for instate inpatient and outpatient hospital services".

10. **A summary of the principal comments and the agency response to them:**
AHCCCS received 4 comments on the proposed rule packet. These comments all resulted in a revision to the rule language.

One comment received was to clarify the language. The 3 transportation providers that submitted comment requested the language be revised to state who is responsible for notifying the Plan of a transport. However, during a discussion at the oral proceeding, it was determined that the real issue was not who was responsible for notification, but the timeframe in which it was to occur. Therefore, the language was revised to allow the transport providers 10 working days rather than 24 hours to notify the Plan of a transport.

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
Not applicable.

12. **Incorporations by reference and their location in the rules:**
29 U.S.C. 1161 et seq., December 19, 1989, incorporated at R9-27-406.

13. **Was this rule previously adopted as an emergency rule?**
Not applicable.

14. **The full text of the rules follows:**

TITLE 9. HEALTH SERVICES

CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED

ARTICLE 1. DEFINITIONS

Section
R9-27-101. Definitions

ARTICLE 2. SCOPE OF SERVICES

R9-27-201. ~~Covered services provided to enrolled members~~ Scope of Services
R9-27-202. Covered ~~services~~ Services
R9-27-203. Excluded ~~services~~ Services
R9-27-204. Out-of- ~~area coverage~~ Service Area Coverage
R9-27-205. Outpatient ~~health services~~ Health Services
R9-27-206. Laboratory, ~~X-ray and medical imaging services~~ Radiology, and Medical Imaging Services
R9-27-207. Pharmaceutical ~~services~~ Services
R9-27-208. Inpatient ~~hospital services~~ Hospital Services
R9-27-209. Emergency ~~medical services~~ Medical Services
R9-27-210. ~~Pre-existing conditions~~ Pre-existing Conditions
~~R9-27-211. Minimum health care benefits, additional services, and charges~~

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-27-301. Eligibility Criteria for Employer Groups
R9-27-302. Eligibility ~~criteria for employee members~~ Criteria for Employee Members

R9-27-303. Eligibility ~~criteria for dependents~~ Criteria for Dependents
R9-27-304. Employer ~~group and employee member eligibility verification~~ Group Member Eligibility Verification
R9-27-305. Health ~~history form~~ History Form
R9-27-306. Effective ~~date of coverage~~ Date of Coverage
R9-27-307. Open ~~enrollment of employee members~~ Enrollment of Employee Members
R9-27-308. ~~Newborn eligibility~~ Enrollment of Newborns
R9-27-309. ~~Newly eligible dependent due to loss of own coverage~~ Enrollment of Newly Eligible Employee and Dependent Due to Loss of Own Coverage
R9-27-310. ~~Reasons for denial of enrollment~~ Denial and Termination of Enrollment

ARTICLE 4. CONTRACTS, ADMINISTRATION, AND STANDARDS

R9-27-401. General
R9-27-402. ~~Contracts~~ Contract
R9-27-403. Subcontracts
R9-27-404. Contract ~~amendments; mergers, reorganizations~~ Amendments
R9-27-405. Contract ~~termination~~ Termination
R9-27-406. Continuation ~~coverage~~ Coverage
R9-27-407. Conversion ~~coverage~~ Coverage
~~R9-27-408.~~ Repealed

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-27-501. Availability and ~~accessibility of services~~ Accessibility of Services
R9-27-502. Reinsurance
R9-27-503. ~~Marketing; prohibition against inducements; misrepresentation; discrimination; sanctions~~ Marketing, Prohibition Against Inducements, Misrepresentation, Discrimination, Sanctions
R9-27-504. ~~Approval of advertisements and marketing material~~ Approval of Advertisements and Marketing Material
R9-27-505. ~~Member records and systems~~ Member Records and Systems
R9-27-506. ~~Fraud or abuse~~ Fraud or Abuse
R9-27-507. ~~Release of safeguarded information~~ Release of Safeguarded Information
R9-27-508. ~~Filing notices and appeals~~ Repealed
R9-27-509. ~~Information to enrolled members~~ Information to Enrolled Members
R9-27-510. ~~Discrimination prohibition~~ Discrimination Prohibition
R9-27-511. ~~Equal opportunity~~ Equal Opportunity
R9-27-512. ~~Periodic reports and information~~ Periodic Reports and Information
R9-27-513. Medical ~~audits~~ Audits
R9-27-514. ~~Health care group plan's internal utilization control system~~ HCG Plan's Internal Quality Management and Utilization Review System
R9-27-515. Continuity of ~~care~~ Care
R9-27-516. Financial ~~resources~~ Resources

ARTICLE 6. GRIEVANCE AND APPEAL PROCESS

R9-27-601. ~~Member grievances~~ Grievances and Appeals
~~R9-27-602.~~ ~~Nonmember grievances~~ Repealed
~~R9-27-603.~~ ~~Other grievances~~ Repealed

ARTICLE 7. STANDARD FOR PAYMENTS

R9-27-701. Scope of ~~health care group Management's liability; payments to health care group plans~~ HCGA's Liability; Payments to HCG Plans
R9-27-702. ~~Prohibition against charges to members~~ Prohibition Against Charges to Members
R9-27-703. Payments by ~~Health Care Group~~ HCG Plans
R9-27-704. ~~Capitated contractor's liability to noncontracting and nonprovider hospitals for the provision of emergency and subsequent care to enrolled members~~ HCG Plan's Liability to Noncontracting and Nonprovider Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members
R9-27-705. ~~Co-payments~~ Copayments

ARTICLE 8. COORDINATION OF BENEFITS

R9-27-801. ~~Priority of benefit payment~~ Priority of Benefit Payment

ARTICLE 1. DEFINITIONS

R9-27-101. Definitions

~~The following words and phrases, in~~ In addition to the definitions contained in A.R.S. Title 36, Chapter 29, ~~have the following meanings~~ unless the context explicitly requires another meaning:

1. "AHCCCS" means the Arizona Health Care Cost Containment System.
2. ~~"AHCCCS hearing officer" means a person designated by the Director to preside over administrative hearings regarding eligibility appeals and grievances.~~
3. ~~2.~~ "Ambulance" means any ~~motor vehicle licensed pursuant to the Arizona Department of Health Services and A.R.S. Title 36, Chapter 21.1, especially designed or constructed, equipped and intended to be used, maintained and operated for the transportation of persons requiring ambulance services.~~vehicle defined in A.R.S. § 36-2201(2).
4. "Clean claim" means one that can be processed without obtaining additional information from the provider of the service or from a 3rd party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
5. "Coinsurance" means a predetermined amount a member agrees to pay to a provider for covered services. A coinsurance payment is a percentage of the fee schedule rate for the services.
6. ~~4.~~5. "Copayment" means a monetary amount specified by the Healthcare ~~Health Care~~ Group Administration which ~~the~~ a member or dependent pays directly to a provider at the time covered services are rendered.
7. ~~5.~~6. "Covered services" means ~~those~~ the health and medical services described in ~~Article 2 of these rules.~~ R9-27-202.
8. ~~6.~~7. "Day" means a calendar day unless otherwise specified in the text.
9. "Deductible" means a fixed annual dollar amount a member agrees to pay for certain covered services before the Healthcare Group Plan agrees to pay.
10. ~~7.~~9. "Dependent ~~subscriber or dependent~~" means the eligible spouse and children of ~~the~~ an employee member under R9-27-303.
11. "Eligible employee" means an employee who is eligible for Healthcare Group coverage under R9-27-302.
12. ~~8.~~11. "Emergency ambulance service" means:
    a. ~~Emergency transportation~~ Transportation by a ~~licensed~~ an ambulance or air ambulance company ~~of~~ for persons requiring emergency medical services.
    b. Emergency medical services ~~which are~~ that are provided by a person certified by the Arizona Department of Health Services to provide the services before, during, or after ~~such transportation by a certified ambulance operator or attendant.~~ a member is

transported by an ambulance or air ambulance company.

12.9. "Emergency medical services" means medical services provided ~~for~~ after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) ~~such~~ that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the patient's health in serious jeopardy;
b. Serious impairment ~~of~~ to bodily functions; or
c. Serious dysfunction of any bodily ~~organ or part;or~~ organ.
~~c. Death.~~

10.13. "Employer group" means the aggregate enrollment of an employed group or business ~~which~~ that is contracting with a ~~Health Care~~ Healthcare Group Plan for covered services.

11.14. "Employee member" means an enrolled ~~member~~ employee of an employer group.

12.15. "Enrollment" means the process by which an employer group or member applies for coverage and contracts with a ~~Health Care~~ Healthcare Group Plan.

13.16. "Full-time employee" means an employee who works at least 20 hours per week and expects to continue employment for at least ~~five~~ 5 months following enrollment.

14.17. "Grievance" means a complaint arising from an adverse action, decision, or policy by a ~~plan~~ Healthcare Group Plan, subcontractor, noncontracting ~~provider~~ provider, or the Healthcare Group Administration, presented by an individual or entity ~~as~~ specified ~~by Article 6 of these rules~~ in R9-27-601.

15.18. "Group Service Agreement (GSA)" means ~~the~~ a contract between ~~the~~ ~~Employer~~ an employer group and ~~the Health Care Group~~ a Healthcare Group Plan.

16.19. "~~Health Care~~ Healthcare Group of Arizona (HCG)" means the registered name of the ~~medical coverage offered by Healthcare Group Plans to employer groups.~~ Healthcare Group Program, which is a prepaid medical coverage product marketed by the Healthcare Group Plans to small uninsured businesses and political subdivisions within the state.

17.20. "~~Health Care Group Management (HCGM)~~ Healthcare Group Administration (HCGA)" means the section within ~~the Administration~~ AHCCCS that ~~will administer the Health Care Group,~~ directs and regulates the continuous development and operation of the HCG Program.

18.21. "~~Health Care~~ Healthcare Group Plan (HCG Plan or Plan)" means a prepaid health plan ~~participating in The Health Care Group which~~ that is currently under contract with the ~~Administration~~ HCGA to provide ~~AHCCCS~~ covered services. ~~In AHCCCS contracts for the provision of state-assisted care, Plans are referred to as "Contractors."~~

19.22. "Hospital" means a health care institution licensed as a hospital by the Department of Health Services ~~pursuant to~~ under A.R.S. Title 36, Chapter 4, Article 2, ~~as a hospital,~~ and certified as a provider under Title XVIII of the Social Security Act, as amended, or is determined by ~~the Administration~~ AHCCCS to meet the requirements of ~~such~~ for certification under Title XVIII of the Social Security Act, as amended.

23. "Inpatient hospital services" means medically necessary services that require an inpatient stay in an acute care hospital. Inpatient hospital services are provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.

20.24. "Life threatening" means any condition for which ~~the time~~ a delay ~~of~~ in obtaining pre-authorization ~~and subsequent travel~~ or traveling to an approved medical facility would have a severe adverse effect on the patient's condition.

21. ~~"Long-Term Care Services" means those services, including nursing services that are ordinarily provided in a nursing care institution, licensed supervisory care facility and adult certified care facility, except for the services specified in R9-22-202.~~

25. "Medical record" means a single, complete record kept at the site of a member's primary care provider which documents the medical services received by the member, including inpatient discharge summary, outpatient care, and emergency care.

22.26. "Medical services" means services pertaining to medical care that are performed at the direction of a physician, on behalf of members by physicians, ~~nurses~~ nurses, or other health ~~related professionals~~ care practitioners and technical personnel.

23.27. "Medically necessary" means ~~those~~ covered services provided by a physician or other ~~licensed~~ health care practitioner ~~of the healing arts~~ within the scope of ~~their~~ the health care practitioner's practice under state law to:

a. Prevent disease, ~~disability~~ disability, and other adverse health conditions or their ~~progression,~~ progression; or
b. Prolong life.

24.28. "Member" means ~~the Health Care Group~~ an employee ~~member~~ or ~~dependents~~ dependent who is enrolled with a HCG Plan.

29. "Noncontracting provider" means a provider who renders covered services to a member but who does not have a subcontract with the member's HCG Plan.

30. "Other health care practitioner" means a person other than a physician who is licensed or certified under Arizona law to deliver health care services.

31. "Outpatient services" means medically necessary services that may be provided in any setting on an outpatient basis (does not require an overnight stay in an inpatient hospital). Outpatient services are provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.

25. ~~"Outpatient health services" means those preventive, diagnostic, rehabilitative or palliative items or services which are ordinarily provided in hospitals, physician's offices and clinics, by licensed health care providers by or under the direction of a physician or practitioner, to an outpatient.~~

26.32. "Pharmaceutical services" means medically necessary drugs prescribed by a ~~primary care~~ physician, a practitioner, ~~or other physician~~ or dentist upon referral by a primary care ~~physician~~ provider and dispensed in accordance with R9-27-207.

27.33. "Physician services" means services provided within the scope of practice of medicine or osteopathy as defined by state law or by or under the personal supervision of an individual licensed under state law to practice medicine or ~~osteopathy and excludes those services routinely performed and not directly related to the medical care of the individual patient, e.g., physician visits to a long term care facility for purposes of 30-60 day certification.~~ osteopathy.

34. "Political subdivision" means the State of Arizona or a county, city, town, or school district within the state.
35. "Primary care practitioner" means a physician's assistant or a registered nurse practitioner who is certified and practicing in an appropriate affiliation with a physician, as authorized by law.
36. "Pre-existing condition" means an illness or injury that is diagnosed or treated within the 12-month period preceding the effective date of coverage.
~~28.~~37. "Premium" means the monthly prepayment submitted to HCGA ~~Health Care Group Management~~ by the employer group.
~~29.~~38. "Pre-payment" means ~~an arrangement in which a contractor agrees to provide health care services for a prospective, predetermined, periodic, fixed subscription premium.~~ submission of the employer group's premium payment 30 days in advance of the effective date of coverage in accordance with R9-27-306.
~~30.~~39. "Prescription" means an order to a provider for covered services, which is signed or transmitted by a provider licensed under applicable state law to prescribe or order ~~such~~ the services.
~~31.~~40. "Primary care provider" ~~physician~~ means a ~~physician who provides medical services at the patient's point of entry into the health care system and coordinates the~~ patient's ~~medical care with necessary specialists and other health professionals~~. primary care physician or a primary care practitioner.
~~32.~~41. "Prior authorization" means the process by which the ~~Health Care Group~~ HCG Plan ~~will determine~~ authorizes, in ~~advance~~ advance, ~~whether~~ the delivery of a covered ~~service~~, services, ~~that requires prior approval, will be reimbursed~~.
~~33.~~42. "Quality ~~Assurance~~ management" means a methodology used by professional health personnel ~~that assesses~~ to assess the degree of conformance to desired medical standards and ~~practices;~~ practices and to implement activities designed to continuously improve and maintain quality service and care, and which is performed through a formal program with involvement of multiple organizational components and committees.
~~34.~~43. "Referral" means the process ~~whereby a member is directed by~~ by which a primary care ~~physician~~ provider directs a member to another appropriate provider or resource for diagnosis or treatment.
~~35.~~44. "Rider or ~~Contract Rider~~ contract rider" means an amendment to the group service agreement between ~~the Employer Group~~ an employer group and a ~~Health Care Group~~ HCG Plan.
~~36.~~45. "Scope of ~~Services~~ services" means ~~those~~ the covered, limited and excluded services ~~set forth~~ listed in ~~Article 2 of these rules. R9-27-201 through R9-27-210~~.
~~37.~~46. ~~"Service Area or Area"~~ "Service area" means the geographic area designated by ~~the Administration~~ HCGA ~~within which~~ where each ~~Health Care Group~~ HCG Plan shall provide covered health care benefits to ~~Members~~ members directly or through subcontracts.
47. "Spouse" means the husband or wife of a HCG member who has entered into a marriage recognized as valid by Arizona.
~~38.~~48. "Subcontract" means an agreement entered into by a ~~Health Care Group~~ HCG Plan with any of the following:
   a. A provider of health care services who agrees to furnish covered services to ~~members.~~ members;
   b. A marketing ~~organization.~~ organization; or
   c. Any other organization.
49. "Subscriber" means an enrolled employee of an employer group.
~~39.~~50. "Subscriber ~~Agreement~~ agreement" means ~~the~~ a contract between ~~the~~ an employee member and ~~Health Care Group~~ HCG Plan.
~~40. "Tier" means the level of coverage (single, single plus one, or family) in which premiums are structured.~~
~~41.~~51. "Utilization control" means ~~the~~ an overall accountability program encompassing quality ~~assurance~~ management and utilization review.
52. "Utilization review" means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided.

ARTICLE 2. SCOPE OF SERVICES

R9-27-201. ~~Covered services provided to enrolled members~~ Scope of Services

~~Covered services shall be provided by, or under the direction of, a primary care physician. Nurse practitioners and physician assistants may provide covered services in affiliation with a primary care physician.~~

A. Each HCG Plan shall provide, either directly or through subcontracts, the covered services specified in this Article.
B. The HCG Plans shall ensure that covered services are provided by, or under the direction of, a primary care provider.
C. The scope of covered services and excluded services may be further delineated or limited in the Group Service Agreement.

R9-27-202. Covered ~~services~~ Services

A. Subject to the exclusions and limitations specified in these rules, the following services ~~will~~ shall be ~~normally~~ covered by the HCG Plans:
   1. Outpatient ~~health services.~~ services;
   2. ~~Laboratory and X-ray~~ Laboratory, radiology, and medical imaging services;
   3. Prescription ~~drugs.~~ drugs;
   4. Inpatient hospital ~~services.~~ services;
   5. Emergency ~~service~~ medical services in and out of ~~area~~ the service area;
   6. Emergency ambulance services; and
   7. Maternity care.
B. The scope of covered services may be expanded or reduced through a rider to the group service agreement with the prior written consent of the ~~Administration~~ HCGA.
C. Any medical service not specifically provided for in this Article or in a rider is not a covered service.

R9-27-203. Excluded ~~services~~ Services

The following services ~~are not~~ shall not be covered:
1. Services or items furnished solely for cosmetic ~~purposes.~~ purposes;
2. Services or items requiring prior authorization for which prior authorization has not been ~~obtained.~~ obtained;
3. Services or items furnished gratuitously or for which charges are not usually ~~made.~~ made;
4. Hearing aids, eye examinations for prescriptive lenses, and prescriptive ~~lenses.~~ lenses;
5. Long-term care services, including nursing ~~services.~~ services;
6. ~~Services of private~~ Private or special duty ~~nurses~~ nursing services, provided ~~except when medically necessary~~ in a hospital unless medically necessary and prior authorized by the Plan Medical Director.
7. Care for health conditions ~~which~~ that are required by state or local law to be treated in a public ~~facility.~~ facility;
8. Care for military service disabilities treatable through governmental ~~services~~ facilities if the member is legally

entitled to ~~such~~ treatment and the facilities are reasonably ~~available.~~ available;

9. Gastric stapling or diversion for weight ~~loss.~~ loss;
10. Reports, evaluations, or physical examinations not required for health reasons including, but not limited to, employment, insurance, or governmental licenses, and court-ordered forensic or custodial ~~evaluations.~~ evaluations;
11. Treatment of temporomandibular joint dysfunction, unless ~~such~~ treatment is prior authorized and determined by the Plan Medical Director or ~~his~~ designee to be ~~essential to the health of a member, and is authorized by the Plan Medical Director or his designee~~ medically necessary;
12. Elective ~~abortions.~~ abortions;
13. Medical and hospital care and costs for the child of a ~~Dependent Subscriber~~ dependent, unless ~~such~~ the child is otherwise eligible under the ~~Agreement~~ GSA;
14. Nonmedical ancillary services including vocational rehabilitation, employment counseling, psychological counseling and training, and physical therapy for learning ~~disabilities.~~ disabilities;
15. Sex change operations and reversal of voluntarily induced infertility ~~(sterilization).~~ (sterilization);
16. ~~Care~~ Services not deemed medically necessary by the Plan Medical Director, or the responsible primary care ~~physician and not specifically provided for in the Health Care Group covered services.~~ provider;
17. ~~Allergy testing and hyposensitization treatment.~~
18. 17. Routine foot ~~care.~~ care;
19. 18. Blood and blood ~~products.~~ products;
20. ~~Surgery which is not medically necessary.~~
21. 19. Human organ transplants, except for cornea and kidney ~~transplants.~~ transplants;
22. 20. Mental health ~~services.~~ services;
23. 21. Durable medical ~~equipment.~~ equipment;
24. 22. Artificial ~~health implants.~~ implants;
25. 23. Dental ~~services.~~ services;
26. 24. Transportation other than emergency ambulance ~~services.~~ services;
27. 25. Psychotherapeutic ~~drugs.~~ drugs;
28. 26. Charges for injuries incurred as the result of participating in a riot, or committing, or attempting to commit a felony or assault, or by suicide ~~attempt.~~ attempt;
29. 27. Early and periodic screening, diagnosis and treatment services ~~(EPSDT).~~ (EPSDT); and
30. 28. In vitro fertilization.

R9-27-204. ~~Out-of-area coverage~~ Out-of-service Area Coverage

~~Coverage out of area is limited to emergencies for members traveling or temporarily outside of their Health Care Group Plan's service area.~~ In accordance with R9-27-209, a member's out-of-area care is limited to emergencies when the member is traveling or temporarily outside of the member's HCG Plan's service area.

R9-27-205. Outpatient ~~health services~~ Health Services

~~The outpatient health service to be provided by Health Care Group Plans are as follows:~~ The HCG Plans shall provide the following outpatient services:

1. Ambulatory surgery and anesthesiology services not specifically ~~excluded.~~ excluded;
2. Physician's ~~services.~~ services;
3. Pharmaceutical services and prescribed drugs to the extent authorized by these ~~rules~~ rules, and applicable provider ~~contracts.~~ contracts;
4. Laboratory ~~services.~~ services;
5. ~~X-ray~~ Radiology and medical imaging ~~services.~~ services;
6. Services of allied other health care ~~professionals practitioners~~ when supervised by a ~~physician.~~ physician;
7. Nursing services provided in an outpatient health care ~~.~~;
8. The use of emergency, examining, or treatment rooms when required for the provision of physician's ~~.~~;
9. Home physician ~~visits~~ visits, as medically necessary ~~.~~;
10. Specialty care physician services referred by a primary care ~~physician.~~ provider;
11. Physical examinations, periodic health examinations, health assessments, physical evaluations, or diagnostic work-ups that include tasks or procedures to:
    a. Determine risk of disease ~~.~~;
    b. Provide early detection of disease ~~.~~;
    c. Detect the presence of injury or disease at any stage ~~.~~;
    d. Establish a treatment plan for injury or disease at any stage ~~.~~;
    e. Evaluate the results or progress of a treatment plan or treatment decision ~~.~~; or
    f. Establish the presence and characteristics of a physical disability ~~which~~ that may be the result of disease or injury.
12. Short-term rehabilitation and physical therapy ~~which,~~ may be provided for a 60-day period, if in the judgment of the Plan Medical Director or ~~his~~ designee, the treatment can be expected to result in the significant improvement of a member's ~~condition within a period of two months from the initial treatment.~~ condition.

R9-27-206. Laboratory, ~~x-ray and medical imaging services~~ Radiology, and Medical Imaging Services

~~Laboratory~~ ~~X-ray~~ The HCG Plans shall provide laboratory, radiology, and medical imaging ~~services~~ services, prescribed by a the member's primary care ~~physician practitioner or physician upon referral from the primary care~~ physician, provider, which are ordinarily provided in hospitals, clinics, physicians' offices and other health facilities by licensed or certified health care ~~providers shall qualify as covered service~~ providers, if medically necessary. Clinical laboratory, ~~X-ray,~~ radiology, or medical imaging service providers must satisfy all applicable state and federal license and certification requirements and shall provide only services ~~which~~ that are within the categories stated in ~~such~~ the provider's license or certification.

R9-27-207. Pharmaceutical ~~services~~ Services

A. ~~Pharmaceutical~~ The HCG Plans shall ensure that pharmaceutical services ~~shall be~~ are available to members during customary business ~~hours and~~ hours. The services shall be located within reasonable travel ~~distance.~~ distance within the Plan's service area.

B. The HCG Plans shall adhere to the following limitations ~~shall apply:~~ when providing a pharmaceutical service:

1. Drugs personally dispensed by a physician or dentist are not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
2. Prescription drugs ~~will be covered~~ are prescribed up to a 30-day supply unless the ~~Health Care Group~~ HCG Plan determines a longer supply is more cost effective.
3. Immunosuppressant (anti-rejection) drugs are covered except when prescribed as part of the post-operative treatment for noncovered organ transplants. However, if a member ~~or dependent~~ is taking ~~such~~ immunosuppressant drugs at the time of enrollment as part of the post-operative treatment for ~~ANY~~ any organ transplant, ~~such~~ the drugs are not covered.

4. Only ~~those~~ drugs ~~which~~ that are not available over-the-counter are covered.

R9-27-208. Inpatient ~~hospital services~~ Hospital Services

A. ~~Inpatient hospital services means medically necessary services provided by or under the direction of a primary care physician, practitioner or by a specialty physician on referral from a primary care physician.~~ The HCG Plans shall provide the following inpatient hospital services: ~~provided by Health Care Group Plans shall be as follows~~
   1. Routine services, including:
      a. Hospital accommodations~~,~~;
      b. Intensive care and coronary care ~~unit~~, units;
      c. Nursing services necessary and appropriate for the member's medical condition~~,~~;
      d. Dietary services~~,~~;
      e. Medical supplies, appliances, and equipment ordinarily furnished to hospital inpatients, billed as part of routine services, and included in the daily room and board charge~~.~~;
   2. Ancillary services, including:
      a. Labor, delivery and recovery rooms, and birthing centers~~,~~;
      b. Surgery and recovery rooms~~,~~;
      c. Laboratory services~~,~~;
      d. Radiological and medical imaging services~~,~~;
      e. Anesthesiology services~~,~~;
      f. Rehabilitation services~~,~~;
      g. Pharmaceutical services and prescribed drugs~~,~~;
      h. Respiratory therapy~~,~~;
      I. Maternity services~~,~~;
      j. Nursery and related services~~,~~;
      k. Chemotherapy~~,~~; and
      l. Dialysis as limited by these rules.

B. Limitations. The HCG Plans shall adhere to the following limitations ~~apply: to inpatient hospital services provided by Health Care Group Plans:~~ when providing inpatient hospital services:
   1. Inpatient hospital accommodations are limited to no more than a semi-private rate, except when patients must be isolated for medical reasons.
   2. Dialysis is limited to services not covered by Title XVIII, of the Social Security Act, as amended.
   3. Alternative levels of care ~~in lieu~~ instead of hospitalization ~~will be~~ are covered when determined cost effective and medically necessary by the ~~Plan~~ Plan's Medical ~~Director~~ Director, or ~~his~~ designee.

R9-27-209. Emergency ~~medical services~~ Medical Services

~~A. In-area emergency services. In-area emergency services all available to members 24 hours a day, seven days a week. In-area emergency services shall be pre-authorized by Health Care Group Plan providers exception the case of life threatening emergencies in which the member has no control over the hospital to which he is taken. In this instance, the plan must be notified within 24 hours. Failure to provide timely notice constitutes cause for denial of payment.~~

A. Emergency medical services provided within the Plan's service area. Emergency medical services shall be available to members 24 hours a day, 7 days a week. The member or provider shall notify the Plan within 24 hours after the initiation of treatment. If a member is incapacitated, the provider is responsible for notifying the Plan. Failure to provide timely notice constitutes cause for denial of payment.

B. ~~Out-of-area emergency~~ Emergency medical services provided outside the Plan's service area which cannot be postponed until the member is able to return to the service area ~~for treatment without risking serious complications~~ are covered. The member or provider shall notify the Plan ~~shall be notified~~ within 48 hours after the initiation of treatment. ~~treatment for a covered service~~. If a member is incapacitated, the provider is responsible for notifying the Plan. Failure to provide timely notice constitutes cause for denial of payment.

C. Ambulance services.
   1. Within the Plan's service area. A member ~~is~~ shall be entitled to emergency ambulance ~~service~~ services within the Plan's service area. ~~Emergency ambulance services shall be pre-authorized by the Plan, except in the case of a life threatening emergency in which case the~~ The provider shall notify the Plan ~~must be notified~~ within ~~24 hours.~~ 10 working days after providing emergency ambulance service to a member. Failure to provide timely notice constitutes cause for denial of payment.
   2. Outside the Plan's service area. A member ~~is~~ shall be entitled to ambulance ~~service~~ services outside the Plan's service area to transport the member to the nearest medical facility capable of providing required emergency ~~service~~ services. The provider shall notify the Plan within 10 working days after providing emergency ambulance service to a member. Failure to provide timely notice constitutes cause for denial of payment.

R9-27-210. Pre-existing ~~conditions~~ Conditions

~~A. A pre-existing condition is an illness or injury which has been diagnosed or treated within the 12-month period preceding the effective date of coverage. Coverage shall not be provided for inpatient services related to a pre-existing condition for 12 months from the effective date of coverage.~~

A. Subject to subsection (C), a HCG Plan shall not cover inpatient services related to a pre-existing condition for 12 months from the effective date of coverage.

B. ~~Pregnancy as a pre-existing condition.~~ A HCG Plan shall not cover inpatient ~~Inpatient~~ costs for the delivery ~~shall not be covered~~ of a child for ~~ten~~ 10 months from the effective date of coverage. ~~For the purpose of coverage and payment, complications of pregnancy shall be treated as new medical conditions and shall not be subject to the pre-existing condition limitation.~~

C. A HCG Plan shall not impose a pre-existing condition exclusion against an eligible employee who meets the following standards:
   1. Newborns from the time of their birth;
   2. Eligible employees who meet the portability requirements of A.R.S. § 20-2308:
      a. A person who had continuous coverage for a 1-year period and during that year had no breaks in coverage totaling more than 31 days; and
      b. The person's prior coverage ended within 60 days before the date of application for enrollment.

D. A HCG Plan shall apply a credit toward meeting the 12 month pre-existing condition exclusion of 1 month for each month of continuous coverage that an eligible employee had under another HCG Plan or accountable health plan in accordance with A.R.S. § 36-2912. Upon request, a contracted health plan or an accountable health plan which provided continuous coverage to an individual shall promptly disclose the coverage provided.

R9-27-211. ~~Minimum health care benefits, additional services, and charges~~ Repealed

~~Each Health Care Group Plan shall provide, directly or through subcontracts, not less than the covered services specified in these rules.~~

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-27-301. Eligibility ~~criteria for employer groups~~ Criteria for Employer Groups

A. ~~All~~ An employer ~~groups~~ group shall ~~be conducting~~ conduct business within ~~the state of~~ Arizona for at least 60 days before making application to be an employer group eligible for HCG coverage. This shall be determined by 1 or more of the following:
   1. Participation in state unemployment ~~insurance,~~ insurance;
   2. Participation in state worker's ~~compensation,~~ compensation;
   3. Possession of a state tax identification ~~number,~~ number; and
   4. Other verifiable proof that the applicant is conducting a business in ~~the state of~~ Arizona.

B. ~~Employer groups,~~ An employer group other than the state of Arizona and political subdivisions of the state, shall have a minimum of ~~one~~ 1 and a maximum of 40 full-time employees at the effective date of ~~their~~ its ~~first~~ 1st contract with a ~~Health Care Group~~ HCG Plan. Acceptable proof of the number of full-time employees may include ~~canceled~~ canceled checks, bookkeeping records, and personnel ledgers.

C. Other than state employees and employees of political subdivisions of the state, 50% of the eligible employees in a group must enroll in order for the employer group to contract with a ~~Health Care Group~~ HCG Plan. Employees with proof of other medical coverage who do not wish to participate in the ~~Health Care Group~~ HCG shall not be considered in determining the percentage.

D. Changes in group size that occur during the term of the Group Service Agreement ~~will~~ shall not affect eligibility.

R9-27-302. Eligibility ~~criteria for employee members~~ Criteria for Employee Members

A. Employee members shall ~~be residents of~~ reside, work, or reside and work in ~~the state of~~ Arizona.

B. Employee members shall be employed by an eligible employer group ~~as described~~ specified in R9-27-301.

C. Employee members shall have been employed ~~for~~ at least 60 consecutive days ~~prior to~~ before the effective date of coverage.

D. Employee members or self-employed persons ~~must~~ shall work for the employer group at least 20 hours per week, with anticipated employment of at least ~~five~~ 5 months following enrollment.

R9-27-303. Eligibility ~~criteria for dependents~~ Criteria for Dependents

A. Eligible dependents of employee members include:
   1. A legal spouse.;
   2. ~~A natural child, adopted child, step-child, a child supported by the employee member pursuant to a valid court order, or a child for whom the employee member is a legal guardian. Such children shall be under the age of 19 or under the age of 24 if a full-time student.~~
   2. Unmarried children less than the age of 19 or less than the age of 24 if a full-time student:
      a. Natural child;
      b. Adopted child;
      c. Step-child;
      d. Child supported by the employee member under a valid court order; and
      e. Child for whom the employee member is a legal guardian; and
   3. A child incapable of self-sustaining support by reason of mental or physical ~~handicap~~ disability existing ~~prior to~~ ~~his~~ before the child's 19th birthday, as determined by the Plan Medical Director or ~~his/her~~ designee.

4.B. Limitations.

~~No service or benefits under the Health Care Group will be extended to the~~ A grandchild of an employee member ~~unless~~ shall be eligible to receive covered services only if the grandchild meets the eligibility requirements of ~~paragraph (2) of this Section~~ R9-27-303(A)(2) and (A)(3).

R9-27-304. Employer ~~group and employee member eligibility verification~~ Group Member Eligibility Verification

A. The ~~Health Care Group~~ HCG Plan shall determine the eligibility status of the employer group and ~~employee member.~~ members.

B. Eligibility verification may be conducted at random or for cause by the ~~Health Care Group Management~~ HCGA or ~~Health Care Group~~ HCG Plan.

R9-27-305. Health ~~history form~~ History Form

~~Prior to~~ Before enrollment, all ~~employee potential members~~ eligible employees and dependents shall complete the HCG health history form. ~~A potential member~~ An eligible employee or dependent shall not be denied enrollment as a result of conditions described on the health history form. However, a pre-existing condition will limit the benefits available to ~~the~~ a member. Failure to provide complete and accurate information on ~~this form~~ the health history form is cause for immediate ~~termination.~~ termination from the HCG Plan.

R9-27-306. Effective ~~date of coverage~~ Date of Coverage

Employer groups shall submit payment 30 days in advance of the effective date of coverage; the effective date of coverage shall be the ~~first~~ 1st day of the month for which the premium ~~is paid.~~ has been pre-paid

R9-27-307. Open ~~enrollment of employee members~~ Enrollment of Employee Members

A. Enrollment of employee members shall occur only during ~~one~~ 1 of the following open enrollment periods:
   1. Thirty days following the ~~initial signing~~ effective date of the Group Service ~~Agreement. by the employer group.~~ Agreement for newly enrolled employer groups;
   2. A 30-day period to start 60 days from the date of employment for a new employee in an enrolled employer group, or a 30-day period after the completion of an employer's waiting period on eligibility for health care coverage, whichever ~~time~~ period is greater.; and
   3. ~~Thirty days following the acquisition of a new dependent.~~
   4.3. A 30-day period to begin 105 days and conclude at least 45 75 days before the employer group's renewal date, as determined by ~~the Administration~~ the HCGA.

B. Enrollment of new dependents shall occur within the 30-day period following the acquisition of a new dependent and in accordance with R9-27-308 if the dependent is a newborn.

R9-27-308. ~~Newborn eligibility~~ Enrollment of Newborns

All newborns shall be enrolled within 30 days of birth to be eligible for coverage. Upon enrollment, the newborn's premium is due to the HCGA within 30 days of birth for coverage retroactive to the 1st day of the month in which the birth occurred.

R9-27-309. ~~Newly eligible dependent due to loss of own coverage~~ Enrollment of Newly Eligible Employee and Dependent Due to Loss of Own Coverage

~~An eligible dependent who had individual or family coverage separate from the member's coverage and who loses that coverage due to termination of employment or retirement may enroll as a dependent subscriber within 30 days of the loss of coverage.~~

A. Eligible employee due to loss of own coverage. An eligible employee who had health care through a spouse, shall be eligi-

ble to enroll as a member within 30 days of the loss of coverage, if that loss of separate coverage was due to:

1. Death of the eligible employee's spouse;
2. Divorce; or
3. Termination of employment of the eligible employee's spouse.

B. Eligible dependent due to loss of own coverage. An eligible dependent, who had individual or family coverage separate from the member's coverage and who loses that coverage due to termination of employment or retirement, shall be eligible to enroll as a dependent member within 30 days of the loss of coverage.

R9-27-310. ~~Reasons for denial of enrollment~~ Denial and Termination of Enrollment

A. An employer ~~group or employee, member~~ group, employee, or dependent who fails to meet the requirements of this Article shall be denied enrollment.

B. Termination of enrollment and coverage for an employer group, employee member, or dependent shall occur on the last day of the month in which:

1. The employer group loses eligibility;
2. The employee member loses eligibility; or
3. The dependent loses eligibility.

C. The HCG Plan may exclude employer groups or employee members from enrollment who have committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.

ARTICLE 4. CONTRACTS, ADMINISTRATION AND STANDARDS

R9-27-401. General

A. Contracts to provide services under the ~~Health Care Group~~ HCG program shall be established between the ~~Administration~~ HCGA and qualified ~~AHCCCS~~ HCG Plans ~~in conformance~~ in accordance with the ~~requirements~~ applicable provisions ~~set forth~~ in this Article and A.R.S. Title 36.

B. Contracts and subcontracts entered into ~~in accordance with~~ under this Article shall become public records on file with the HCGA unless otherwise made confidential by law. ~~Administration.~~

R9-27-402. Contracts

A. ~~In order to have a~~ To contract with the ~~Administration to provide services under the Health Care Group,~~ HCGA, a health plan must ~~have a current AHCCCS contract to provide state-assisted care~~ meet the requirements of A.R.S. § 36-2912.

B. Each contract shall be in writing and ~~shall contain~~ contain, at ~~least~~ a minimum, the following information:

1. ~~Full disclosure of the~~ The method and amount of compensation or other consideration to be received by the ~~Health Care Group Plan.~~ HCG Plan;
2. ~~Identification of the~~ The name and address of the ~~Health Care Group Plan.~~ HCG Plan;
3. ~~Identification of the~~ The population and geographic service area to be covered by the contract.~~;~~
4. The amount, duration, and scope of medical services to be provided, or for which compensation will be paid.~~;~~
5. ~~Specification of the~~ The term of the contract, including the beginning and ending dates, as well as methods of extension, ~~renegotiation~~ re-negotiation, and termination.~~;~~
6. A provision that the ~~Health Care Group~~ HCG Plan arrange for the collection of any required ~~copayment~~ copayment, coinsurance, deductible, and ~~third-party~~ 3rd-party insurance.~~;~~
7. A provision that the HCG Plan will not bill or attempt to collect from ~~the~~ a member for any covered service except as may be authorized by statute, these ~~rules~~ rules, or ~~Contract Riders~~ contract riders that ~~which~~ have been approved by the ~~Administration.~~ HCGA;
8. A provision that the contract will not be assigned or transferred without the prior written approval of the ~~Administration.~~ HCGA;
9. ~~A provision that specifies procedures~~ Procedures for enrollment of the covered population.~~;~~
10. ~~A provision that specifies procedures~~ Procedures and criteria for terminating or suspending the contract.~~;~~ and
11. ~~An agreement to~~ A provision that the HCG Plan will hold harmless and indemnify the state, ~~Health Care Group Management, the Administration~~ AHCCCS, HCGA, and members against claims, liabilities, judgments, ~~costs~~ costs, and expenses with respect to 3rd parties, which may accrue against the state, ~~Health Care Group Management, the Administration~~ AHCCCS, HCGA, or members, through the negligence or other action of the ~~contractor.~~ HCG Plan.

R9-27-403. Subcontracts

A. Approval. Any subcontract entered into by a ~~Health Care Group~~ HCG Plan to provide covered services to ~~Health Care Group~~ HCG members is subject to review and approval of the ~~Administration.~~ HCGA. No subcontract alters the legal responsibility of the ~~contractor~~ HCG Plan to the ~~Administration~~ HCGA to ~~assure~~ ensure that all activities under the contract are carried out.

B. Subcontracts. Each subcontract shall be in writing and include:

1. A specification that the subcontract ~~shall~~ will be governed by and construed ~~in accordance with~~ under all laws, ~~rules~~ rules, and contractual obligations of the ~~Health Care Group~~ HCG Plan.
2. ~~An agreement to~~ A provision that the HCG Plan will notify ~~the Health Care Group Management~~ the HCGA in the event the ~~agreement~~ subcontract with the ~~Health Care Group~~ HCG Plan is amended or terminated.
3. ~~An agreement~~ A provision that assignment or delegation of the subcontract ~~shall be~~ is void unless prior written approval is obtained from the ~~Administration.~~ HCGA.
4. An agreement to hold harmless the state, ~~Health Care Group Management,~~ AHCCCS, the ~~Administration~~ HCGA, and members in the event the ~~Health Care Group~~ HCG Plan is unable to or does not pay for covered services performed by the subcontractor.
5. A provision that the subcontract and subcontract amendments are subject to review and prior written approval by the ~~Administration as set forth in these rules~~ HCGA and that a subcontract or subcontract amendment may be terminated, ~~rescinded~~ rescinded, or ~~cancelled~~ canceled by the ~~Administration~~ HCGA for violation of ~~the provisions~~ a provision of these rules.
6. An agreement to hold harmless and indemnify the state, ~~Health Care Group Management,~~ AHCCCS, the ~~Administration~~ HCGA, and members against claims, liabilities, judgments, ~~costs~~ costs, and expenses with respect to 3rd parties, which may accrue against the state, ~~Health Care Group Management, the Administration~~ AHCCCS, the HCGA, or members, through the negligence or other action of the subcontractor.
7. ~~Full disclosure of the~~ The method and amount of compensation or other consideration to be received by the subcontractor.

8. The amount, ~~duration~~ duration, and scope of medical services to be ~~provided or~~ provided by the subcontractor, for which compensation will be paid.

C. A HCG Plan may submit a written request to the ~~Administration~~ HCGA requesting a waiver of the requirement that a the Plan subcontract with a hospital in the Plan's service area. The request shall ~~set forth~~ state the reasons ~~therefore~~ for requesting a waiver and ~~shall state~~ all efforts that have been made to secure ~~such a subcontract.~~ a subcontract with a hospital within the Plan's service area. For good cause shown, the ~~Administration~~ HCGA may waive the hospital subcontract requirement. The ~~Administration~~ HCGA shall consider the following criteria in deciding whether to waive the hospital subcontract requirement:
1. The number of hospitals in the service area~~.~~;
2. The extent to which the HCG Plan's primary care ~~physicians~~ providers have staff privileges at noncontracting hospitals in the service area~~.~~;
3. The size and population of, and the demographic distribution within, the service area~~.~~;
4. ~~Patterns~~ The patterns of medical practice and care within the service area~~.~~;
5. Whether the HCG Plan has diligently attempted to negotiate a hospital subcontract in the service area~~.~~;
6. Whether the HCG Plan has any ~~hospital~~ subcontracts in adjoining areas with hospitals that are reasonably accessible to the Plan's members in the service area~~.~~; and
7. Whether the HCG Plan's members can reasonably be expected to receive all covered services in the absence of a hospital subcontract.

R9-27-404. Contract ~~amendments; mergers; reorganizations~~ Amendments

Any merger, ~~reorganization~~ reorganization, or change in ownership of a ~~Health Care Group~~ HCG Plan or subcontractor affiliated with the HCG Plan shall constitute a contract ~~amendment~~ amendment. ~~which requires the prior~~ The HCG Plan shall obtain written approval ~~of~~ from the ~~Administration~~. HCGA ~~Additionally~~, before any merger, ~~reorganization~~ reorganization, or change in ownership of a the HCG Plan or subcontractor that is related to or affiliated with the ~~Health Care Group Plan~~ HCG Plan. ~~shall constitute a contract amendment which requires prior written approval of the Administration.~~ To be effective, contract amendments shall be ~~reduced to~~ submitted in writing to the HCGA and executed by both parties.

R9-27-405. Contract ~~termination~~ Termination

A. Contract between the ~~Administration~~ HCGA and ~~Health Care Group~~ HCG Plan. The ~~Administration~~ HCGA may suspend, deny, refuse, fail to renew, or terminate a contract or require the HCG Plan to terminate a subcontract for good cause which may include the following reasons:
1. ~~Failure of the Health Care Group Plan to receive and maintain an AHCCCS contract for the provision of state-assisted care.~~
2. Submission of any misleading, ~~false~~ false, or fraudulent information~~.~~;
3. Provision of any services in violation of or not authorized by licensure, certification, or other law~~.~~;
4. A material breach of contract~~.~~;
5. Failure to provide and maintain quality health care services to members, as determined by standards established by the state; and
6. Failure to reimburse a medical ~~providers~~ provider within 60 days days of receipt of ~~valid claims~~ a clean claim unless a different period is specified by contract.

B. ~~Contract~~ Group Service Agreement between ~~Health Care Group~~ HCG Plan and employer group.
1. The ~~contract~~ GSA may be terminated with written notice from either the HCG Plan or employer to the other party no more than 60 ~~days~~ days, and at least 45 days ~~prior to~~ before the ~~Anniversary~~ anniversary date ~~or~~ of the ~~Agreement.~~ GSA.
2. The ~~contract~~ GSA may be terminated by the HCG Plan for cause with 45 10 days' written notice for the following:
   a. Material misrepresentation of information furnished by the employer to the ~~Plan.~~ Plan, or
   b. ~~For employer's~~ Employer's default in payment of premiums time being of the essence.
3. The ~~contract~~ GSA may be terminated by the employer group ~~on~~ or the HCG Plan with 45 days' written notice for a material breach of the contract.

C. ~~Contract between the~~ Termination of an employee member ~~and Health Care Group Plan.~~ by the HCGA or HCG Plan.
1. Cause for immediate termination of coverage. The ~~Health Care Group Administration~~ HCGA or ~~Health Care Group~~ HCG Plan may terminate an employee member's coverage ~~of an employee member immediately~~ for the following:
   a. Fraud or misrepresentation when applying for ~~the Subscriber Agreement~~ coverage or obtaining services; or
   b. ~~Violence and threatening behavior~~ Violence, or threatening or other substantially abusive behavior toward the HCGA or the HCG Plan employees or agents, or contracting or noncontracting providers or their employees or agents.
2. Cause for termination with 30 days written notice. The ~~Health Care Group Management~~ HCGA or the ~~Health Care Group~~ HCG Plan may terminate coverage of an employee member for the following reasons:
   a. Repeated and unreasonable demands for unnecessary medical services;
   b. Failure to pay any ~~copayment~~ copayment, coinsurance, deductible, or required financial obligation; and
   c. Material violation of any provision of the Group Service Agreement.
3. Termination by reason of ineligibility.
   a. Termination of employment~~.~~;
   b. Failure of employer or employee to pay premium. Termination shall be effective the 1st day of the month for which the premium has not been paid~~.~~;
   c. Coverage of a dependent member shall automatically cease on the last day of the month in which the dependent member ~~terminates employment and~~ loses coverage, ~~or upon the death or divorce of the member subsequent to continuation and conversion coverage; under Article 4 of these rules~~ for any reason described in R9-27-406 and R9-27-407.
   d. Subject to continuation coverage and conversion ~~coverage under Article 4 of these rules,~~ coverage, as described in R9-27-406 and R9-27-407, on the effective date of termination of coverage, the HCG Plan shall have no further obligation to provide services and benefits to ~~the~~ a member whose coverage has been ~~so~~ terminated; except that a member confined to a hospital at the effective date of termination shall continue to receive coverage ~~under the Agreement~~ until there has been a determination by the HCG Plan Medical Director or ~~his~~ designee that care

in the hospital is no longer medically necessary for the condition for which the member was admitted to the hospital.; and

e. An employee member whose coverage terminates pursuant according to this Subsection will subsection shall not be eligible for re-enrollment until the employer group's next open enrollment. enrollment period. The employee shall meet all the eligibility criteria prescribed by these rules prior to before re-enrollment.

D. The HCG Plan may exclude employer groups or employee members from enrollment who have committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.

R9-27-406. Continuation coverage Coverage

Employer groups with at least 20 employees on a typical business day during the preceding calendar year shall provide continuation coverage as required by Sections 10001 and 10002 of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), 29 U.S.C. 1161 et seq., December 19, 1989, incorporated by reference herein and on file with the HCGA and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments. The employer group shall collect the premium from the employee and pay the premium to the Administration. HCGA.

R9-27-407. Conversion coverage Coverage

This Section applies only to employee members and dependents and employee members of employer groups with fewer than 20 employees.

1. An employee member member, dependent, or a qualified beneficiary who loses eligibility for any reason other than for cause a qualifying event, as defined in 29 U.S.C. 1163, and who has been covered for at least three 3 months under the employer group enrollment GSA may convert the policy to an individual policy for a period of 180 days. All dependents covered at the time of the employee member's loss of eligibility may also be covered under the conversion policy. The spouse or dependents may convert upon the death or divorce of the employee member.
2. A member shall have 30 days after the end date of termination of group coverage to convert the coverage and pay the initial premium. Any services used within that the 30-day conversion period prior to before payment of the initial premium shall not be covered unless the care was provided or authorized by the member's primary care physician provider or the HCG Plan.
3. The A member shall pay the premium for the converted coverage shall be paid directly to the Administration and HCGA. Converted coverage shall be retroactive to the end date of termination of group coverage.

R9-27-408. Contracting Repealed

Contracts to provide services under the Health Care Group shall be awarded in accordance with the provisions of R9-22-601 et seq. The Arizona Procurement Code, A.R.S. § 41-2501 et seq., and rules promulgated thereunder shall also apply to contracts between Plans and the Administration, except to the extent that they are inconsistent with these rules or Title 36, Chapter 29 Arizona Revised Statutes.

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-27-501. Availability and accessibility of services Accessibility of Services

A. Health Care Group HCG Plans shall provide available, accessible and ensure that, within each service area, an adequate numbers number of institutional hospitals, medical care facilities, and service locations, service sites, professional, allied and paramedical personnel providers are available and reasonably accessible for the provision of to provide covered services, to members, including all emergency medical care on a 24 hours a day, 7 days a week basis. The Health Care Group At a minimum, a HCG Plan shall have or provide the following as a minimum: shall:

1. A Have a designated emergency medical services facility, providing care on a 24 hours a day, 7 days a week basis. 24 hours a day, 7 days a week. Emergency medical services facilities shall be accessible to members in each contracted service area. area with at least 1 One or more physicians physician and one nurse shall be on call or on duty at such the facility at all times.
2. An Have an emergency medical services system employing at least one 1 physician, registered nurse, physician's assistant assistant, or nurse practitioner, accessible to members by telephone 24 hours a day, 7 days a week basis, week, for more to provide information in the event of an emergency, as defined by these rules, and to providers who need verification of patient membership and treatment authorization. authorization; and in the case of an emergency as defined under emergency medical services in R9-27-101.
3. An emergency services call log containing: member's name, address, telephone number, date of call, time of call, nature of complaint or problem, and instructions given each member.
3. Maintain an emergency medical services call log that contains the following information:
   a. Member's name,
   b. Member's address,
   c. Member's telephone number,
   d. Date of call,
   e. Time of call, and
   f. Instructions given to each member.
4. A written procedure plan for the communication of emergency medical services information to the member's primary care physician provider and other appropriate organizational units.
5. An appointment system for each of its the HCG Plan's service locations. The appointment system shall assure ensure that:
   a. Members with acute or urgent problems shall be are triaged and provided same-day service when necessary.;
   b. Time-specific appointments for routine medically necessary care from the primary care physician shall be provider are available within three 3 weeks of a member's request and on the same day for emergency care.; and
   c. Referral appointments to specialists must be are in the same day for emergency care, within three 3 days for urgent care care, and within 30 days for routine care.
6. One primary care provider who an enrolled member may select or to whom the member may be assigned. This physician is responsible for supervising, coordinating and referrals for specialty care; and maintaining continuity of patient care. Health Care Group Plans whose organization does not ordinarily include primary care physicians shall enter into affiliation or subcontract with organizations or individuals to provide such primary care; the Health Care Group Plans shall agree to provide services under the primary care physicians guidance and direction.

6. One primary care provider that an enrolled member may select or to whom the member may be assigned. HCG Plans whose organization does not ordinarily include primary care providers shall enter into affiliation or subcontract with an organization or individuals to provide primary care. The HCG Plans shall agree to provide services under the primary care provider's guidance and direction. The primary care provider is responsible for:
   a. Supervising, coordinating, and providing initial and primary care to patients;
   b. Initiating referrals for specialty care; and
   c. Maintaining continuity of patient care.
7. Primary care physicians and specialists providing inpatient services to members must have staff privileges in a minimum of ~~one~~ 1 general acute care hospital under subcontract with the contracting health plan, within or near the service area of the ~~Health Care Group~~ HCG Plan.

R9-27-502. Reinsurance

A. Reinsurance may be provided by ~~Health Care Group Management~~ the HCGA through private reinsurers. ~~No state funds shall be used to pay premiums or otherwise reinsure members.~~
B. For purposes of the ~~Health Care Group Management's~~ HCGA's reinsurance program, the insured entities ~~will~~ shall be the ~~Health Care Group~~ HCG Plans with which the ~~Administration~~ HCGA contracts.
   1. A specified amount per ~~member~~ member, per ~~month~~ month, ~~will~~ shall be deducted by the ~~Health Care Group Management~~ HCGA from the ~~Health Care Group~~ HCG Plan's monthly premium to cover the cost of the reinsurance contract.
   2. The HCG Plan shall ~~be responsible for~~ ~~complying~~ comply with the reimbursement requirements of the reinsurance agreement between the reinsurer and the HCGA. ~~Administration~~.

R9-27-503. Marketing; ~~prohibition against inducements, misrepresentation, discrimination, sanctions~~ Prohibition Against Inducements, Misrepresentation, Discrimination, Sanctions

A. Marketing representatives shall not misrepresent themselves, the ~~Health Care Group~~ HCG Plan or the ~~AHCCCS~~ HCG program through false advertising, ~~statements~~ false statements, or in any other manner in order to induce members of other contracting entities to enroll in a ~~given health plan~~ particular HCG Plan.
   ~~1. Violations of this subsection shall include, but not be limited to, false or misleading claims, inferences or representations that:~~
      ~~a. Marketing representatives are employees of the state representatives of the Administration, a county or any health plan other than the health plan with whom they are employed or by whom they are reimbursed.~~
      ~~b. The health plan is recommended or endorsed as superior to its competition by any state or county agency or any other organization which has not certified its endorsement in writing to such health plan and the Administration.~~
B. Marketing representatives shall not claim, infer, or falsely represent themselves to be employees of the state or representatives of the HCGA, a county, or a HCG plan other than the HCG Plan with whom they are employed or by whom they are reimbursed.
~~B.~~ C. Marketing representatives shall not engage in any marketing or other pre-enrollment practices that discriminate against an eligible person or member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental ~~handicap~~ disability, or health status.
~~C.~~ D. ~~Health Care Group~~ HCG Plans shall bear responsibility for the performance of any marketing representative, subcontractor or agent, ~~program~~ program, or process under their employ or direction.

R9-27-504. ~~Approval of advertisements and marketing material~~ Approval of Advertisements and Marketing Material

A. ~~Health Care Group Plans~~ The HCG Plans shall submit to the HCGA for review and approval proposed ~~advertisements~~, marketing ~~strategies~~, strategies and marketing materials ~~shall be reviewed and approved by the Health Care Group Management prior to distribution of~~ before distributing the marketing materials or ~~implementation of~~ implementing any activities. The proposed marketing strategies and materials shall be submitted in writing to the HCGA.
~~B. All proposed materials and strategies shall be submitted in writing to the Health Care Group Management~~
~~C.~~ B. The ~~Health Care Group Management~~ HCGA ~~will~~ shall review and approve or disapprove all proposed marketing materials and strategies ~~for approval or disapproval~~. The HCGA shall notify the HCG Plan in writing of the approval or disapproval of the proposed marketing materials and marketing strategies. ~~A notice of disapproval will be accompanied by~~ The notification shall include a statement of objections and recommendations.
~~D.~~ C. To minimize the expense of revising ~~advertising~~ marketing materials or other copy, a HCG Plan may submit the material ~~may be submitted~~ in draft form subject to final approval and filing of a proof or final copy.
~~E.~~ D. ~~Two~~ HCG Plans shall submit 2 copies of the proof or final approved copy of materials ~~shall be submitted to and maintained by the Health Care Group Management.~~ to the HCGA, which shall maintain the proof or copy for 5 years.

R9-27-505. Member ~~records and systems~~ Records and Systems

Each ~~Health Care Group~~ HCG Plan shall maintain a member service record that ~~will contain~~ contains encounter data, grievances, ~~complaints~~ complaints, and service information for each member.

R9-27-506. Fraud or ~~abuse~~ Abuse

All ~~Health Care Group~~ HCG Plans, ~~providers~~ providers, and nonproviders shall advise the ~~Health Care Group Management~~ HCGA immediately in writing of suspected fraud or abuse.

R9-27-507. Release of ~~safeguarded information~~ Safeguarded Information

A. Information to be safeguarded concerning ~~applicants or members~~ an applicant or member of ~~the Health Care Group~~ a HCG Plan ~~include~~ includes:
   1. ~~Names, addresses~~ Name, address, and social security ~~numbers~~ number;
   2. Evaluation of personal information~~,~~; and
   3. Medical data and services including diagnosis and ~~past~~ history of disease or disability.
B. Unrestricted information. The restrictions upon disclosure of information shall not apply to summary data, ~~statistics~~ utilization data, and other information ~~which do not~~ that does not identify an individual applicant or member.
C. ~~The use or disclosure of~~ Safeguarded information concerning a member or applicant shall be ~~limited~~ disclosed only to:
   1. The ~~member,~~ member or applicant, or, in the case of a minor, the ~~member's~~ parent, custodial relative, or guardian~~,~~;
   2. Individuals authorized by the member~~,~~ or applicant; and

3. Persons or agencies for official purposes.
4. Safeguarded information may be released to these parties only under the conditions specified in subsections (D), (E) and (F) ~~in this Section~~.

D. ~~The~~ A member or authorized representative may view ~~his or her~~ the member's medical record after written notification to the provider and at a reasonable time and place.

E. Release to individuals authorized by the individual concerned. ~~Medical~~ A HCG Plan shall release medical records and any other ~~Health Care Group~~ HCG-related confidential information of ~~applicants or members may be released~~ a member or applicant to individuals authorized by the member or applicant only under the following conditions:
1. Authorization for release of information must be obtained from the member, applicant, ~~member~~ or authorized representative. In the case of a minor, the member's or applicant's parent, custodial relative, or guardian shall submit an authorization for release of information.
2. Authorization used for release of information must be a ~~written document~~, submitted in writing separate from any other document, and must specify the following:
   a. Information or records, in whole or in part, which are authorized for release;
   b. To whom the release shall be made;
   c. The period of time for which the authorization is valid, if limited; and
   d. The dated signature of the member, applicant or authorized representative. In the case of a minor member or applicant, signature of a parent, custodial ~~relative~~ relative, or ~~designated representative~~ guardian is required unless the minor is ~~capable and sufficiently mature~~ able to understand the consequences of authorizing and not authorizing.
3. If a grievance or appeal has been filed, the grievant, appellant, or designated representative shall be permitted to review, obtain, or copy any nonprivileged record necessary for the proper presentation of the case. The grievant or appellant also may authorize release of safeguarded information deemed necessary to the contested issue, to any opposing party in the case.

F. Release to persons or agencies for official purposes.
1. ~~Medical record. The Health Care Group Management may release safeguarded information contained in the member's medical record to law enforcement officials without the member's consent only in situations of suspected cases of fraud and abuse against the Health Care Group program.~~
2. 1. ~~Review committees. For official purposes, safeguarded~~ Safeguarded information, case records, and medical services information may be disclosed without the consent of the member, to ~~members~~, agents or employees of a review ~~committees~~ committee. ~~in accordance with the provisions of A.R.S. § 36-2917.~~
2. For purposes of this Section, "review committee" means an organizational structure within the Plan whose primary purpose is to:
   a. Evaluate and improve the quality of health care;
   b. Review and investigate the conduct of licensed health care providers to determine whether disciplinary action should be imposed; and
   c. Encourage proper and efficient utilization of health care services and facilities.
3. Any member, agent, or employee of a review committee, who in good faith and without malice, furnishes records, information or assistance related to the duties of the review committee; or, who takes an action or makes a decision or recommendation related to the duties or functions of the review committee shall not be subject to liability for civil damages as a consequence of the action. This does not relieve a person of liability that arises from that person's medical treatment of a patient.
4. Information considered by a review committee related to the duties or functions of the committee, including records of their actions and proceedings, are confidential and are not subject to subpoena or order to produce except:
   a. When otherwise subject to discovery as a patient's medical records.
   b. In proceedings before an appropriate state licensing or certifying agency. If the information is transferred to an appropriate state licensing or certifying agency, the information shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions.
5. A member of a review committee or staff engaged in work for the committee or any other person assisting or furnishing information to the review committee shall not be subpoenaed to testify in a judicial or quasi-judicial proceeding if the subpoena is based solely on review committee activities.

G. ~~Subcontractors~~ Subcontracting providers shall not be required to obtain written approval from the member before transmitting member medical records to physicians:
1. Providing services to members under subcontract with the ~~Health Care Group~~ HCG Plan; or
2. Retained by the subcontractor to provide services that are infrequently used or are of an unusual nature.

R9-27-508. ~~Filing notices and appeals~~ Repealed

~~All notices and appeals or other statements shall be considered filed for the purpose of these rules when received in writing by the Administration.~~

R9-27-509. Information to ~~enrolled members~~ Enrolled Members

A. Each ~~Health Care Group~~ HCG Plan shall produce and distribute a printed ~~information~~ member handbook to each enrolled member by the effective date of coverage. The ~~information materials~~ member handbook shall ~~be provided in writing. Information materials shall~~ include the following:
1. A description of all available services and an explanation of any service limitation, and exclusions from coverage or charges for services, when applicable;
2. An explanation of the procedure for obtaining covered services, including a notice stating ~~that Health Care Group~~ the HCG Plan shall only be liable for services authorized by a member's primary care ~~physician~~ provider or the Plan;
3. A list of the names, telephone ~~numbers~~ numbers, and ~~service site~~ business addresses of primary care ~~physicians~~ providers available for selection by the member, and a description of the selection process, including a statement that informs members ~~that~~ they may request another primary care ~~physician, in the event that~~ provider, if they are dissatisfied with their selection;
4. Locations, telephone ~~numbers~~ numbers, and procedures for obtaining emergency health services;
5. Explanation of the procedure for obtaining emergency health services outside the ~~Health Care Group~~ HCG Plan's service area;
6. The causes for which a member may lose coverage;
7. A description of the grievance procedures;

8. ~~Co-payment~~ Copayment, coinsurance, and deductible schedules;
9. Information on the appropriate use of health services and on the maintenance of personal and family health;
10. Information regarding emergency and medically necessary transportation offered by the ~~Health Care Group~~ HCG Plan; and~~,~~
11. Other information necessary to use the program.

B. Notification of changes in services. Each ~~Health Care Group~~ HCG Plan shall ~~revise~~ prepare and distribute to members a printed member handbook ~~service guide~~ insert describing any changes ~~which~~ that the ~~Health Care Group~~ HCG Plan proposes to make in services provided ~~or in~~ within the Plan's service ~~locations.~~ areas. The insert shall be distributed to all affected members or family units at least 14 days ~~prior to~~ before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in ~~services, sites~~ services or service locations.

R9-27-510. Discrimination ~~prohibition~~ Prohibition

A. A ~~Health Care Group~~ HCG Plan shall not discriminate against an applicant or member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex or physical or mental ~~handicap~~ disability in accordance with Title VII of the U.S. Civil Rights Act of 1964, 42 U.S.C., Section 2000 D, ~~rules~~ regulations promulgated ~~pursuant thereto,~~ under the Act, or as otherwise provided by law or regulation. For the purpose of providing covered ~~service~~ services under contract ~~pursuant to~~ under A.R.S. Title 36, Chapter 29, discrimination on the grounds of race, creed, color, religion, ancestry, marital status, age, sex, national origin, sexual preference, or physical or mental disability ~~handicap~~ includes, but is not limited to, the following:
   1. Denying a member any covered service or availability of a facility for any reason except as defined in a rider provided under R9-27-202 or for a pre-existing condition as described in ~~Section R9-27-501;~~ R9-27-210;
   2. Providing to a member any covered service ~~which~~ that is different, or is provided in a different manner or at a different time from that provided to other ~~Health Care Group~~ HCG members under contract, except where medically indicated;
   3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service, or restricting a member in any way in ~~his or her~~ the member's enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
   4. ~~The assignment~~ Assigning ~~of~~ times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, or physical or mental ~~handicap~~ disability of the participants to be served.

B. ~~The Health Care Group~~ A HCG Plan shall take affirmative action to ensure that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental ~~handicap,~~ disability, except where medically indicated.

R9-27-511. Equal ~~opportunity~~ Opportunity

~~The Health Care Group Plan shall, in all solicitations or advertisements for employees placed by or on behalf of the Health Care Group Plan, state that it is an equal opportunity employer, and will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice, to be provided by the Health Care Group Management, advising the labor union or worker's representative of the Health Care Group Plan's commitment as an equal opportunity employer an shall post copies of the notice in conspicuous places available to employees and applicants for employment.~~

A HCG Plan shall comply with the following equal opportunity employment requirements:

1. State in all solicitations or advertisements for employees placed by or on behalf of the HCG Plan, that it is an equal opportunity employer; and
2. Send a notice provided by the HCGA, to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding. The notice shall advise the labor union or workers' representative of the HCG Plan's commitment as an equal opportunity employer and shall be posted in conspicuous places available to employees and applicants for employment.

R9-27-512. Periodic ~~reports and information~~ Reports and Information

A. Upon request by the ~~Administration,~~ HCGA, each ~~Health Care Group~~ HCG Plan shall furnish to the ~~Health Care Group Management~~ HCGA information from its records relating to contract performance.

B. Each ~~Health Care Group~~ HCG Plan shall maintain records to identify separately all ~~Health Care Group~~ HCG-related transactions.

R9-27-513. Medical ~~audits~~ Audits

~~Health Care Group Plans shall comply with the requirements set forth in R9-22-521.~~

A. HCGA shall conduct a medical audit of each HCG Plan at least once every 12 months. Unless HCGA determines that advance notice will render a medical review less useful, the HCGA shall notify the HCG Plan approximately 3 weeks in advance of the date of an on-site medical review. HCGA may conduct, without prior notice, inspections of the HCG Plan facilities or perform other elements of a medical review, either in conjunction with the medial audit or as part of an unannounced inspection program.

B. As part of the medical audit, the HCGA may perform any or all of the following procedures:
   1. Conduct private interviews and group conferences with:
      a. Members;
      b. Physicians and other health care practitioners;
      c. Members of the HCG Plan's administrative staff including, but not limited to, its principal management persons; and
   2. Examine records, books, reports, and papers of the HCG Plan, any management company of the HCG Plan, and all providers or subcontractors providing health care and other services to the HCG Plan. The examination may include, but is not limited to:
      a. The minutes of medical staff meetings;
      b. Peer review and quality of care review records;
      c. Duty rosters of medical personnel;
      d. Appointment records;
      e. Written procedures for the internal operation of the HCG Plan;
      f. Contracts;
      g. Correspondence with members and with providers of health care services and other services to the HCG Plan; and
      h. Additional documentation deemed necessary by the HCGA to review the quality of medical care.

R9-27-514. ~~Health care group plan's internal utilization control system~~ HCG Plan's Internal Quality Management and Utilization Review System

~~Healthcare Group Plans shall comply with the requirements set forth in R9-22-522.~~

A. The HCG Plans shall comply with the following quality management and utilization review requirements:
   1. Prepare and submit to HCGA for review and approval annually a written quality management plan which includes utilization review. The quality management plan must be designed and implemented with actions to promote the provision of quality health care services.
   2. Design and implement procedures for continuously reviewing the performance of health care personnel and the utilization of facilities, services, and costs.
   3. Medical records and systems.
      a. Ensure that member's medical records are maintained by the primary care provider, and include a record of all medical services received by the member from the HCG Plan and its subcontracting and noncontracting providers.
      b. Ensure that medical records are maintained in a manner that:
         i. Conforms to professional medical standards and practices;
         ii. Permits professional medical review and medical audit processes; and
         iii. Facilitates a system for follow-up treatment.
   4. Develop and implement a program of utilization review methods for hospitals that, at a minimum, includes:
      a. Prior authorization of nonemergency hospital admissions;
      b. Concurrent review of inpatient stays; and
      c. Retrospective review of hospital claims to ensure that covered hospital services are not used unnecessarily or unreasonably.

B. The HCG Plan's utilization control system is subject to evaluation by the HCGA to determine cost effectiveness, and to measure whether quality management and utilization review methods are reducing, controlling, or eliminating unnecessary or unreasonable utilization. The HCG Plan may subcontract with an organization or entity designed to conduct activities regarding prior authorization, concurrent review, retrospective review, or any combination of these activities. A subcontract to conduct quality management or utilization review activities is subject to prior approval by the HCGA.

R9-27-515. Continuity of ~~care~~ Care

~~Each Healthcare Group~~ A HCG Plan shall establish and maintain a system to ~~assure~~ ensure continuity of care which ~~shall~~ includes:
1. Referral of members needing specialty health care services;
2. Monitoring of members with chronic medical conditions;
3. Providing hospital discharge planning and coordination including post-discharge care; and
4. Monitoring the operation of the system through professional review activities.

R9-27-516. Financial ~~resources~~ Resources

A. A ~~Health Care Group~~ HCG Plan shall demonstrate to the ~~Health Care Group Management~~ HCGA that it has adequate financial reserves, administrative ~~abilities~~ abilities, and soundness of program design to carry out its contractual obligations.

B. ~~Contract provisions required by the Health Care Group Management may include, but are not limited to, the maintenance of deposits, performance bonds, financial reserves or other financial security.~~

B. Contract provisions required by the HCGA may include, but are not limited to:
   1. The maintenance of deposits;
   2. Performance bonds;
   3. Financial reserves; or
   4. Other financial security.

ARTICLE 6. GRIEVANCE AND APPEAL PROCESS

~~R9-27-601.~~ ~~Member grievances~~

~~A. A member aggrieved by any adverse decision or action by a Health Care Group Plan, subcontractor, noncontracting provider, nonprovider or Health Care Group Management, may file a grievance and request a hearing as specified in this section.~~

~~B. Member grievances to Health Care Group Plan.~~
   ~~1. All grievance filed by members relating to the Health Care Group Plan, subcontractor, noncontracting provider, or nonprovider shall be filed with the member's Health Care Group Plan for review, investigation and resolution in accordance with the grievance requirements of this Subsection and the applicable contract.~~
   ~~2. All grievances shall be filed in writing with the member's Health Care Group Plan not later that than 35 days after the date of such adverse decision or action.~~
   ~~3. The Health Care Group Plan shall record and retain sufficient information to identify the grievant, date of receipt and nature of the grievance.~~
   ~~4. A final decision shall be rendered by the Health Care Group Plan contractor on grievances that involve issues related to continuity or delivery of medical services within 15 days of filing. A final decision shall be rendered by the Health Care Group Plan on all other grievances within 30 days of filing. A copy of the decision by the Health Care Group Plan shall be personally delivered or mailed by regular mail to all parties and shall state the basis for the decision as well as information regarding the individual's right to appeal the decision to Health Car Group Management.~~
   ~~5. At the time of enrollment, each member shall be given material explaining grievance procedures available through the Health Care Group Plan and through Health Care Group Management.~~

~~C. Member's appeal or grievance to the Health Care Group Management.~~
   ~~1. Member's may appeal to and request a hearing from the AHCCCS Appeal and Grievance Division if:~~
      ~~a. the member files a written notice of appeal not more than 15 days after the date of the final decision of the Health Care Group Plan. The date of the final decision shall be the date of personal delivery to the member or the date of mailing.~~
      ~~b. In the event that a decision was not timely rendered by the Health Care Group Plan in accordance with the provisions of this Section, the member may file a written notice of appeal not more than 60 days after the date the grievance was filed with the Health Care Group Plan, based upon the Health Care Group Plan's failure or refusal to timely decide the grievance in a timely manner.~~
      ~~c. The member has a grievance against Health Care Group Management and files the grievance not more than 35 days after the date of adverse decision or action by the Health Care Group Management.~~
   ~~2. If the Appeal and Grievance Division is unable to resolve the appeal to the appellant's satisfaction, a hearing will be scheduled.~~

~~D. AHCCCS Hearing Officer decision.~~
~~1. The Notice of Hearing shall be in accordance with A.R.S. § 41-1061.~~
~~2. The hearing shall be conducted before an AHCCCS Hearing Officer designated by the Director and held in accordance with A.R.S. §§ 41-1061 and 41-1062.~~
~~3. After the conclusion of the hearing, the AHCCCS Hearing Officer shall prepare written findings of fact and conclusions of law and render a recommended decision to the Director.~~

~~E. Decision of the Director. After receipt of the Hearing Officer's recommended decision, the Director shall issue his or her decision in writing, which shall include findings of fact and conclusions of law, and unless otherwise provided by law, personally deliver or mail by certified mail a copy thereof to all parties at their last known residence or place of business. A petition for rehearing or review shall be filed not later than 15 days after the date of the Director's decision. The date of the Director's decision shall be the date of personal delivery to the member or the date of mailing.~~

~~F. Request for rehearing or review.~~
~~1. Unless the Director determines in the decision that good cause exists otherwise, an aggrieved party may petition the Director for rehearing or review of the decision for any of the following causes which materially affects the appellant's rights:~~
~~a. Irregularity in the proceedings of the hearing or appeal whereby the aggrieved party was deprived of a fair hearing or appeal.~~
~~b. Misconduct of a party of the agency,~~
~~c. Newly discovered material evidence, which with reasonable diligence could not have been discovered and produced at the hearing.~~
~~d. That the decision is the result of passion or prejudice, or~~
~~e. That the decision is not justified by the evidence or is contrary to law.~~
~~2. The petition for review or rehearing shall be in writing and shall specify the grounds upon which the petition is based. The Director shall review the sufficiency of the evidence if the petition is made upon the ground that the decision is not justified by the evidence.~~
~~3. The Director may open the decision, order the taking of additional testimony or evidence before the Hearing Officer, amend findings of fact and conclusions of law or make new findings and conclusions, and render a final decision.~~
~~4. The Director's final decision made pursuant to this Subsection shall be a final administrative decision and may be reviewed as provided by A.R.S. § 12-901 et seq. the date of the Director's final decision shall be the date of personal delivery to the member or the date of mailing by certified mail.~~

~~G. Failure to submit a grievance and appeal within the time frames specified in this Section shall constitute a failure to exhaust administrative remedies required as a condition to seeking a judicial relief.~~

R9-27-601. Grievances and Appeals

A. The provisions of this Article provide the exclusive manner through which any individual or entity may grieve against the HCGA, the HCG Plans, or both in connection with any adverse action, decision, or policy.

B. Definitions. For the purpose of this Article:
1. "Appellant" means the individual or entity filing any grievance or appeal under this Article.
2. "Request for hearing" means an appeal of an adverse eligibility action; an appeal filed after an informal decision has been rendered on a grievance by the HCGA; an appeal of a grievance decision rendered by a HCG Plan; or an appeal filed because a HCG Plan has failed to render a timely grievance decision.
3. "Respondent" means the party responsible for the action being grieved or appealed. In most grievances, the HCG Plan is the respondent.

C. Filing grievances and appeals. Unless provided elsewhere in this Chapter, all grievances and appeals or other statements shall be considered filed when received in writing by the HCGA.

D. Computation of time. In computing any period of time for establishing timeliness of filing grievances and appeals, the period shall commence the day after the act, event, or decision grieved or appealed, and shall include all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period shall be extended until the end of the next day which is not a weekend or a legal holiday.

E. Direct grievances to the HCGA.
1. A grievance may be filed directly with the HCGA only by HCG Plans or by individuals or entities grieving an adverse action, decision, or policy actually made or enacted by the HCGA. If the aggrieved adverse action, decision, or policy actually was made by a HCG Plan, the appellant shall 1st file the grievance with the HCG Plan responsible for the decision, policy or action being grieved, so that the HCG Plan may investigate and resolve the grievance in accordance with this Article and any applicable contracts.
2. Except as provided in subsection (E)(3), all written grievances shall be filed with and received by the HCGA not later than 35 days after the date of the adverse action, decision, or policy implementation being grieved.
3. Written grievances regarding claim denials shall be filed not more than 12 months after the date of the service for which payment is claimed. If the claim is denied less than 35 days before the expiration of the 12-month time period, the dissatisfied party shall have 35 days from the date of the denial to file the grievance.
4. All grievances shall state with particularity the factual and legal basis and the relief requested. Failure to comply with the specificity requirements shall result in the denial of the grievance.
5. The HCGA or its designee, in its sole discretion, may investigate the grievance and render a written informal decision before scheduling a hearing. A hearing shall be scheduled if any party timely requests a hearing within 15 days of the postmark date of the informal decision.
6. Pending final resolution of a grievance, appeal, or request for judicial review, a grieving HCG Plan shall proceed diligently with the performance of the contract and in accordance with the HCGA, its designee, or the Director's Decision.
7. If a hearing is requested, it shall be conducted according to the provisions in this Article.

F. Grievances to HCG Plans.
1. Except as provided in subsection (F)(2), all grievances shall be filed with and received by the appropriate HCG Plan not later than 35 days after the date of the adverse action or decision.
2. Written grievances regarding claim denials shall be filed not more than 12 months after the date of the service for which payment is claimed. If the claim is denied less

than 35 days before the expiration of the 12-month time period, the dissatisfied party shall have 35 days from the date of the denial to file the grievance.

3. All grievances shall state with particularity the factual and legal basis and the relief requested. Failure to comply with the specificity requirement shall result in the denial of the grievance.

4. A final decision shall be rendered by the HCG Plan on grievances that involve issues related to continuity or delivery of medical services within 15 days of filing. A final decision shall be rendered by the HCG Plan on all other grievances within 30 days of filing unless the parties agree on a longer period. The decision by the HCG Plan shall be personally delivered or mailed by certified mail to the parties, and it shall state the basis for the decision as well as the appellant's right to appeal the decision to the HCGA. The HCG Plan's final decision shall specify the manner in which an appeal to the HCGA may be filed.

5. The HCG Plan shall record and retain information to identify the appellant, date of receipt, and nature of the grievance.

6. At the time of enrollment, HCG Plans shall give to members written information regarding grievance procedures available through the HCG Plan and the HCGA.

G. Appeal of HCG Plan decisions to the HCGA.

1. After 1st grieving to the appropriate HCG Plan, an appellant may appeal to and request a hearing from the HCGA or designee if:
   a. The appellant files a written notice of appeal not more than 15 days after the date of the final decision of the HCG Plan, which is the earlier of the date of personal delivery or the postmark date of certified mail; or
   b. A decision is not timely rendered by the HCG Plan, and the appellant files a written notice of appeal based upon the HCG Plan's failure or refusal to timely decide the grievance.
2. The HCGA or its designee, in its sole discretion, may investigate the grievance and render a written informal decision before scheduling a hearing. A hearing shall be scheduled if any party timely requests a hearing within 15 days of the postmark date of the informal decision.
3. If a hearing is requested, it shall be conducted according to the provisions in this Article.

H. Appellant's hearing rights. The Administration shall afford an appellant the right to:

1. Have a hearing that is conducted as specified in A.R.S. §§ 41-1061 and 41-1062.
2. Obtain copies of any relevant documents from the respondent or from the HCGA at the appellant's expense.
3. Appear at the hearing and be heard in person, by telephone if available, through a representative designated in writing by the appellant, or to submit to the HCGA a written statement that is signed and notarized before the hearing.
4. Bring an interpreter to assist at the hearing.
5. Be provided an interpreter by the Administration if hearing-challenged according to A.R.S. § 12-242.

I. Withdrawal or denial of a request for hearing.

1. The HCGA or designee shall deny a request for hearing and deny a grievance or appeal if a written request for withdrawal is received from the appellant before the date of the hearing. The case file shall then be closed.
2. The HCGA or designee may deny a request for hearing and dismiss a grievance or appeal upon written determination if:
   a. The request for hearing is untimely;
   b. The request for hearing, grievance, or appeal is not for a reason permitted under this Article; or
   c. The appeal is otherwise moot.

J. Notice of Hearing. The Notice of Hearing shall be in accordance with A.R.S. § 41-1061 and shall include a statement detailing how an appellant may request a change in the scheduled hearing date.

K. Postponement.

1. The HCGA or designee's own motion may postpone a hearing. When a request for postponement is made by a party, it shall be in writing and received by the HCGA or designee no later than 5 days before the scheduled hearing date. The HCGA or designee may grant a request for postponement on a showing that:
   a. There is good cause for the postponement; and
   b. The cause is beyond the reasonable control of the party making the request.
2. If a postponement is granted, the hearing shall be rescheduled at the earliest practicable date.

L. Failure to appear for hearing. If any party or representative fails to appear at the hearing without good cause or a postponement, the HCGA or designee may:

1. Proceed with the hearing;
2. Reschedule the hearing with further notice;
3. Issue a decision based on the evidence of record; or
4. Issue a default disposition.

M. Conduct hearing. The hearing shall be conducted as specified in A.R.S. §§ 41-1061 and 41-1062.

1. The hearing shall be conducted in an informal manner without formal rules of evidence or procedure.
2. The HCGA or designee may:
   a. Hold prehearing conferences to settle, simplify, or identify issues in a proceeding, or to consider other matters that may aid in the expeditious disposition of the proceeding;
   b. Require parties to state their positions concerning the various issues in the proceeding;
   c. Require parties to produce for examination those relevant witnesses and documents under their control;
   d. Rule on motions and other procedural items;
   e. Regulate the course of the hearing and conduct of participants;
   f. Establish time limits for submission of motions or memoranda;
   g. Impose appropriate sanctions against any individual failing to obey an order under these procedures, which may include:
      i Refusing to allow the individual to assert or oppose designated claims or defenses, or prohibiting that individual from introducing designated matters in evidence;
      ii. Excluding all testimony of an unresponsive or evasive witness; and
      iii. Expelling the individual from further participation in the hearing.
   h. Take official notice of any material fact not appearing in evidence in the record, if the fact is among the traditional matter of judicial notice; and
   i. Administer oaths or affirmations.

N. Recommended decision. After the conclusion of the hearing, unless the appellant withdraws or the parties stipulate to a settlement, the hearing officer of the HCGA or designee shall

prepare written findings of fact and conclusions of law and render a recommended decision to the Director.

O. Decision of the Director.

1. The Director may affirm, modify, or reject the recommended decision in whole or in part; may remand a matter to any party or the hearing officer with specific instructions; or make any other appropriate disposition.
2. The Director shall mail by certified mail a copy of the decision to all parties at their last known residences or places of business.

P. Petition for rehearing or review.

1. A party dissatisfied with the decision may petition the Director for rehearing or review of the decision for any of the following causes which materially affects the appellant's rights:
   a. Irregularity in the proceedings of the hearing or appeal that caused the aggrieved party to be deprived of a fair hearing or appeal;
   b. Misconduct of a party or the HCGA;
   c. Newly discovered material evidence, which with reasonable diligence could not have been discovered and produced at the hearing;
   d. That the decision is the result of passion or prejudice; or
   e. That the decision is not justified by the evidence or is contrary to law.
2. The petition for rehearing or review shall be filed not later than 15 days after the date of the Director's decision, which is the postmark date of the decision. The moving party shall also send a copy of the petition to all other parties. If a timely petition for rehearing or review is filed, the Director's decision is not a final administrative decision; rather, the Director shall render a final decision which is the final administrative decision.
3. The petition for rehearing or review shall be in writing and shall specifically state the grounds upon which it is based. The Director shall review the sufficiency of the evidence if the petition is made upon the ground that the decision is not justified by the evidence.
4. The Director may remand the case to any party; reopen the decision; order the taking of additional testimony or evidence before the hearing officer; amend findings of fact and conclusions of law; make new findings and conclusions; render an amended decision; or deny the petition and affirm the previous decision.
5. The Director, within the time for filing a petition for rehearing or review, may on the Director's own motion order a rehearing or issue an amended decision for any reason for which the Director might have done so upon petition of any party.

Q. Failure to submit a grievance, appeal, request for hearing, or petition for rehearing or review in a timely manner shall constitute a failure to exhaust administrative remedies required as a condition to seeking judicial relief.

R9-27-602. ~~Nonmember grievances~~ Repealed

~~A. An employee who applies to be a member may request a hearing by filing a written grievance with the AHCCCS Appeal and Grievance Division.~~

~~B. The written grievance shall be filed with and received by the Appeal and Grievance Division not later than 35 days after the date of adverse decision or action being grieved.~~

~~C. If the Appeal and Grievance Division is unable to resolve the grievance to the grievant's satisfaction, a hearing shall be conducted and decision rendered, in accordance with the provisions of R9-27-601 of these rules.~~

~~D. Failure to submit a grievance and appeal within the time frames specified in this Section shall constitute a failure to exhaust administrative remedies required as a condition to seeking judicial relief.~~

R9-27-603. ~~Other grievances~~ Repealed

~~A. The provisions of this Section provide the exclusive manner through which Health Care Group Plans, subcontractors, providers, noncontracting providers and nonproviders; may grieve against Health Care Group Management, its agents and Health Care Group Plans in connection with any adverse action, decision, or policy.~~

~~B. Grievances. Entities specified in subsection (A) may grieve by filing a written grievance with the AHCCCS Appeal and Grievance Division.~~

~~1. The written grievance must be filed and received by the Administration not later than 35 days after the date of such action, decision, or policy implementation by the Administration.~~
~~2. The grievance shall contain a concise statement of the grounds upon which the grievance is made and the relief requested.~~
~~3. The Administration shall investigate the grievance and render a written decision regarding the grievance or schedule a grievance for a hearing in accordance with provisions of this Subsection. A copy of the decision shall be personally delivered or mailed by certified mail to all parties.~~

~~C. Appeals. A party may appeal the Administration's grievance decision by filing a request for hearing with the Director not later than 15 days after the date of the Administration's grievance decision. The date of grievance decision shall be the date of personal delivery to the grievant or the date of mailing.~~

~~1. The Notice of Hearing will be in accordance with A.R.S. § 41-1061.~~
~~2. The hearing shall be conducted before an AHCCCS Hearing Officer designated by the Director and held in accordance with A.R.S. §§ 41-1061 and 41-1062.~~
~~3. After the conclusion of the hearing, the AHCCCS Hearing Officer shall prepare written findings of fact and conclusions of law and render a recommended decision to the Director.~~

~~D. Decision of the Director. After receipt of the Hearing Officer's recommended decision, the Director shall issue his or her decision in writing, which shall include findings of fact and conclusions of law, and, unless otherwise provided by law, personally deliver or mail by certified mail a copy thereof to all parties at their last known residence or place of business. A petition for rehearing or review shall be filed not later than 15 days after the date of the Director's decision. The date of the Director's decision shall be the date of personal delivery to the grievant or the date of mailing.~~

~~E. Request for rehearing or review.~~

~~1. Unless the Director determines in his decision that good cause exists otherwise, an aggrieved party may petition the Director for rehearing or review of the decision for any of the following causes which materially affects the grievant's rights:~~
   ~~a. Irregularity in the proceedings of the hearing or appeal whereby the aggrieved party was deprived of a fair hearing or appeal,~~
   ~~b. Misconduct of a party or the agency,~~
   ~~c. Newly discovered material evidence, which with reasonable diligence could not have been discovered and produced at the hearing,~~
   ~~d. That the decision is the result of passion or prejudice, or~~

e. That the decision is not justified by the evidence or is contrary to law.

2. The petition for review or rehearing shall be in writing and shall specify the grounds upon which the petition is based. The Director shall review the sufficiency of the evidence if the petition is made upon the ground that the decision is not justified by the evidence.

3. The Director may open the decision, order the taking of additional testimony of evidence before the Hearing Officer, amend findings of fact and conclusions of law or make new findings and conclusions, and render a final decision.

4. The Director's final decision made pursuant to this Subsection shall be a final administrative decision and may be reviewed as provided by A.R.S. § 12-901 et seq. The date of the Director's final decision shall be the date of personal delivery to the grievant or the date of mailing by certified mail.

E. Pending final resolution of a grievance, appeal, or request for judicial review, a grieving contractor shall proceed diligently with the performance of the contract and in accordance with the Health Care Group Management or Director's decision.

G. Failure to submit a grievance or appeal within the time frames specified in this Section shall constitute a failure to exhaust administrative remedies required as a condition to seeking judicial relief.

ARTICLE 7. STANDARD FOR PAYMENTS

R9-27-701. Scope of the HCGA's Liability; Payments to HCG Plans health care group Management's liability; payments to health care group plans

A. The Health Care Group Management HCGA shall bear no liability for the provision of covered services or the completion of a plan of treatment to any member.

B. All payments to Health Care Group HCG Plans shall be made pursuant to under the terms and conditions of contracts executed between the Health Care Group HCG Plan and the Administration and HCGA in accordance with these rules.

C. The Health Care Group Management HCGA shall bear no liability for subcontracts which that the Health Care Group HCG Plan may execute executes with other parties for the provision of either administrative or management services, medical services, covered health care services services, or for any other purpose. The Health Care Group HCG Plan shall indemnify and hold the Health Care Group Management HCGA harmless from any and all liability arising from these subcontracts the HCG Plan's subcontracts. The HCG Plan and shall bear all costs of defense of any litigation over such liability and shall satisfy in full any judgment entered against the Health Care Group Management in such connection. HCGA arising from a HCG Plan subcontract. All deposits, bonds, reserves, and security posted pursuant to under R9-27-516 shall be held by the Administration HCGA to satisfy the obligations of this Section.

D. Premium payments, less Health Care Group Management Administrative HCGA administrative charge charges and reinsurance fees, shall be paid monthly to those Health Care Group HCG Plans who that have either posted required performance bonds or have otherwise provided sufficient security to the Health Care Group Management HCGA.

R9-27-702. Prohibition against charges to members Against Charges to Members

No Health Care Group HCG Plan Plan, or subcontractor subcontractor, noncontracting provider, or nonprovider reimbursed by a HCG Plan shall charge, submit a claim, demand, or otherwise collect payment from a member or person acting on behalf of a member for any covered service except to collect an authorized copayments copayment, coinsurance, and deductibles deductible. This prohibition shall not apply if the Administration HCGA determines that the member willfully withheld information pertaining to his the member's enrollment in a Plan. Health Care Group HCG Plans shall have the right to recover from a member that portion of payment made by a 3rd party to the member when such the payment duplicates Health Care Group HCG benefits and has not been assigned to the Health Care Group HCG Plan.

R9-27-703. Payments by Health Care Group HCG Plans

A. Health Care Group Payment for covered services. A HCG Plans Plan shall pay for all covered services rendered their to the Plan's members where such if the services have been were arranged by their the Plan's agents or the Plan's employees, subcontracting providers, or other individuals acting on behalf of the Health Care Group HCG Plan's Plan and behalf for which if necessary authorization has been was obtained.

B. Payment for medically necessary outpatient services. Health Care Group A HCG Plans Plan shall reimburse subcontracting providers and nonsubcontracting noncontracting providers for the provision of covered health care services to their members, provided to the Plan's members. Reimbursement shall be made within the time period specified by contract between a Health Care Group HCG Plan and a subcontracting entity or within 60 days of receipt of valid accrued claims a clean claim, if a time period is not specified.

C. Payment for hospital inpatient and emergency services. Health Care Group Plans shall reimburse in-state subcontracting and noncontracting providers for the provision of hospital inpatient and emergency services rendered at the lower of negotiated discounted rates or adjusted billed charges, according to the requirements set forth in A.R.S. § 36-2904. Health Care Group Plans shall reimburse out-of-state hospitals for the provision of hospital inpatient and emergency services at the lower of negotiated discounted rates or 80% of billed charges. Payment for instate inpatient and outpatient hospital services including emergency services. HCG Plans shall reimburse instate subcontracting providers for the provision of inpatient and outpatient hospital services, including emergency services, at the subcontracted rate. HCG Plans shall reimburse instate noncontracting providers for the provision of inpatient and outpatient hospital services, including emergency services, in accordance with the reimbursement methodology stipulated in A.R.S. § 36-2903.01(J).

1. Health Care Group HCG Plans shall pay for all emergency care services rendered their members by noncontracting noncontracting providers when such if the services:
   a. Conform to the definition of emergency medical services defined in Article 1 and Article 2 of these rules,; and
   b. Conform to the notification requirements set forth in Article 2 of these rules.
2. Health Care Group HCG Plans shall provide written notice to claimants providers whose claims are denied or reduced by the Health Care Group HCG Plan within 30 days of adjudication of such the claims. This notice shall include a statement describing the provider's right to:
   a. Grieve the Health Care Group HCG Plan's rejection or reduction of the claim;, and
   b. Submit a grievance to the AHCCCS Appeal and Grievance Division, HCGA, or its designee pursuant to under Article 6 of these rules.

D. Payment for out-of-state inpatient and outpatient hospital services. The HCG Plans shall reimburse out-of-state subcon-

tracting providers at the subcontracted rate. The HCG Plans shall reimburse out-of-state noncontracting providers for the provision of inpatient and outpatient hospital services at the lower of negotiated discounted rates or 80% of billed charges.

E. Payment for emergency ambulance services. The HCG Plans shall reimburse out-of-state subcontracting providers at the subcontracted rate. The HCG Plans shall reimburse noncontracting providers for emergency ambulance services at the lower of negotiated discounted rates or 80% of the billed charges.

R9-27-704. ~~Capitated Contractor's liability to noncontracting and nonprovider hospital for the provision of emergency and subsequent care to enrolled members~~ HCG Plan's Liability to Noncontracting and Nonprovider Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members

A. For purposes of ~~Health Care Group~~ HCG Plan liability, an emergency medical condition shall be subject to reimbursement only until ~~such~~ the time as the ~~patient's~~ member's condition is stabilized and the ~~patient~~ member is transferable to a subcontractor, or until the ~~patient~~ member is discharged following ~~stabilization~~ stabilization, subject to the requirements of A.R.S. § 36-2909(E) and Article 2 of these rules.

B. Subject to subsection ~~(A) of this Section, in the event that~~ (A), if a member cannot be transferred following stabilization to a facility ~~which~~ that has a subcontract with the ~~Health Care Group~~ HCG Plan of ~~record following stabilization, the Health Care Group~~ record, the HCG Plan shall pay for all appropriately documented medically necessary treatment provided ~~such~~ the member ~~prior to~~ before the date of discharge or transfer at the lower of a negotiated discounted rate or ~~adjusted billed charges~~ prospective tiered-per-diem rate. ~~whichever is less.~~

C. ~~In the event that~~ If a member refuses transfer from a nonprovider or noncontracting hospital to a hospital affiliated with the member's ~~Health Care Group~~ HCG Plan, neither the ~~Health Care Group Management~~ HCGA nor the ~~Health Care Group~~ HCG Plan shall be liable for any costs incurred subsequent to the date of refusal ~~when~~ if:

1. Subsequent to consultation with ~~his Health Care Group~~ the member's HCG Plan, the member continues to refuse the transfer~~,~~; and
2. The member has been provided and signs a written statement of liability, ~~prior to~~ before the date of transfer ~~of liability~~, informing ~~him~~ the member of the medical and financial consequences of ~~such refusal~~ refusing to transfer. If the member refuses to sign a written statement, ~~then~~ a statement signed by ~~two~~ 2 witnesses indicating that the member was informed may be substituted.

~~R9-27-705. Copayments~~

~~A. Co-payments shall be collected from members and shall fall within the following ranges~~

~~Outpatient physicians services, including specialist referral authorized by the Plan physician~~	~~$0 - $10.00~~
~~Prescription drugs~~	~~$0 - $5.00~~
~~Emergency room visit~~	~~$0 - $50.00~~

~~B. The exact co-payments will be established in the contract between the Administration and the Plan.~~

~~C. Co-payments may be waived by agreement between the employer group and the Plan.~~

~~D. The Plan shall be responsible for the collection of co-payments.~~

R9-27-705. Copayments

A. A member shall be required to pay a copayment directly to a provider at the time covered services are rendered.

B. The HCGA shall establish the amount of copayment a member shall be charged. The HCGA shall consider the following in determining the amount of copayment:

1. The impact the amount of the copayment will have on the population served; and
2. The copayment amount charged by other group health plans or health insurance carriers for particular services.

C. The HCGA shall include the copayment provisions in its contract with a HCG Plan.

D. The HCG Plans shall provide a schedule of the copayments to members at the time of enrollment.

ARTICLE 8.COORDINATION OF BENEFITS

R9-27-801. ~~Priority of benefit payment~~ Priority of Benefit Payment

A. ~~Health Care Group~~ HCG Plans shall ~~be responsible for the coordination of~~ coordinate all 3rd-party benefits. Services provided under the ~~health care group~~ HCG are not intended to duplicate other services and benefits available to an employee member.

B. If a member has other coverage, payment for services shall occur in the following order:

1. A policy, plan, or program ~~which~~ that has no coordination of benefits provision or nonduplication provision shall make payment 1st.
2. If a member is covered by another a plan or policy which has a coordination of ~~benefits, then:~~ benefits:
   a. ~~If a member is covered by another prepaid health plan, the~~ The plan ~~which~~ that provided or authorized the service shall make payment 1st.
   b. ~~If the other plan is not a prepaid plan, which~~ A plan that is not a prepaid plan that covers a person as an employee ~~will pay~~ shall make payment before a plan that ~~which~~ covers a the person as a dependent.
3. ~~Relative to paying a claim for~~ If coverage is provided to a dependent child ~~where~~ and both parents have family coverage:
   a. The plan of the employee whose birthday occurs 1st in the calendar year ~~will~~ shall be primary, and the plan of the employee whose birthday occurs last in the calendar year ~~will~~ shall be secondary.
   b. If both employees have the same birthday, the plan of the employee, that has been in force longer ~~will~~ shall pay 1st.
   c. If 1 of the plans determines the order of benefits based upon the gender of an employee, and the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits. ~~when paying a dependent child's claim~~
4. ~~In the event a child is covered as a dependent~~ If coverage is provided to a dependent child of divorced employees, the order of benefit ~~determination relative to paying a claim for the dependent child is~~ shall be:
   a. The plan of the employee with custody of the child ~~will~~ shall pay 1st;
   b. The plan of the spouse of the employee with custody of the child ~~will~~ shall pay ~~second~~, 2nd; and
   c. The plan of the employee not having custody of the child ~~will~~ shall pay last.

C. HCG Plans shall not be primary payers for claims involving workers' compensation, automobile insurance, or homeowner's insurance.

D.	HCG Plans shall not have lien or subrogation rights beyond those held by health care services organizations licensed under	A.R.S. § Title 20, Chapter 4, Article 9.